County of Los Angeles - Department of Mental Health
Countywide Housing, Employment and Education Resource Development
Federal Housing Subsidies Unit

HACoLA SHELTER PLUS CARE / CoC APPLICATION COVERSHEET & CHECKLIST - (rev. 01/11/17)

Client Name:_____ SS#:_____
Name of Agency:DMH /_____ Service Area: _____ Supr. District _____
Housing Liaison:_____ Case Manager:_____
Housing Liaison Phone #:_____ Case Manager Phone #:_____
Housing Liaison Fax #:_____ Case Manager Fax #:_____
Housing Liaison Email:_____ Case Manager Email:_____

The following forms are required for every applicant under the Section 8 Homeless Program. In order for the Housing Authority to expedite the process of reviewing and approving your referrals, please complete all forms thoroughly. Place a check mark next to those documents included in this application packet and arrange forms in the following order:

_____ 1. HACoLA Shelter Plus Care / CoC Application Coversheet and Checklist (DMH form)
_____ 2. Certification of No Conflict of Interest (HACoLA form signed by client)
_____ 3. Certification of No Conflict of Interest (DMH form signed by Case Manager)
_____ 4. Housing Intake and Needs Assessment, 3 pgs (DMH form)
_____ 5. HMIS Intake and Enrollment Form (LAHSA form) to be completed for **each adult and minor** in the household
_____ 6. MH 677 LA/OC HMIS – Authorization for Use/Disclosure of PHI, 2 pgs (DMH form)
_____ 7. MH 677 HACoLA – Authorization for Use/Disclosure of PHI, 2 pgs (DMH form)
_____ 8. LACDMH Notice of Privacy Practices: **Acknowledgement of Receipt**, 1 pg (DMH form)
_____ 9. SPC Service Provider Responsibility Form, 2 pgs (DMH form)
_____ 10. SPC Client Agreement (DMH form)
_____ 11. Authorization to Release Information
_____ 12. Affordable Care Act Certification Form (DMH form)
_____ 13. McKinney Vento Act Notice – Acknowledgment of Receipt (DMH form)
_____ 14. CES Referral Form, completed by the CES Regional Leads for applicants prioritized though CES **only**
_____ 15. Agency Referral Letter (Include a 3-year timeline of housing / homelessness history and explanation of address on ID if different from current address & why client can't return there.)
___ Third Party Verification Letter (from shelter, transitional residence, etc., on agency letterhead)
_____ 16. Program Transmittal/Referral Form – Continuum of Care
_____ 17. Continuum of Care Program Application Checklist
_____ 18. HACoLA Application for Rental Assistance, 12 pgs (This form is not on the web, contact FHSU)
_____ 19. Non-Discrimination Policy
_____ 20. Supplement to Application for Federally Assisted Housing
_____ 21. Authorization for the Release of Information/Privacy Act Notice, 2 pgs
_____ 22. Authorization for Release of Information, 2 pgs
_____ 23. Debts Owed to Public Housing Agencies and Terminations, 2 pgs
_____ 24. Department of Public and Social Services (DPSS) Verification Form
_____ 25. Declaration of Citizenship/Eligible Immigration Status, (Signed by all household members)
_____ 26. Consent Form to Verify Immigration Status with the U.S. Citizenship and Immigration Services
_____ 27. Certificate of Disability, 2 pgs
_____ 28. Declaration of Eligibility for Assisted Housing Programs (Signed by all household members)
_____ 29. HACoLA Homeless Condition Certification, 7 pgs (Must be completed by referring agency)
_____ 30. CoC Program Chronic Homeless Definition Certification, 3 pgs (Must be completed by referring agency)
_____ 31. Continuum of Care Out of Service Area Agreement
_____ 32. Verification Consent Form
_____ 33. Listing of Non-Contending Family Members
_____ 34. Move-In Notification Agreement
_____ 35. Request for Reasonable Accommodation
_____ 36. Parent/Guardian Authorization for Housing Authority to Obtain Sex Offender Registration Information of a Minor (Complete for **each** household member between the ages of 13 through 17 years old.)
_____ 37. General Affidavit
_____ 38. Verification of Income (refer to item #15 on this checklist for examples of verification that apply)
_____ 39. Identification Documents for **each** household member
___ Copy of CA ID/DL for **each** adult household member ___ Copy of Birth Certificate
___ Copy of signed Social Security Card

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES
ASSISTED HOUSING DIVISION
P.O. Box 1510 • Alhambra • California 91802
Tel: 626.262.4510 • TDD: 855.892.6095 • www.hacola.org

For Office Use	
ID:	

CERTIFICATION OF NO CONFLICT OF INTEREST

***By signing below*,** I certify that I have read and understood the following Continuum of Care Program Conflict of Interest prohibition which is applicable to me:

PROHIBITIONS

(check one)

☐ I hereby certify that I nor any person listed under the household composition of my Housing Authority application have a relationship (by family, marriage or domestic partnership) with employees of the Housing Authority of the County of Los Angeles (HACoLA) or the Service Provider, Los Angeles County Department of Mental Health , who has involvement with the file of or who exercises any function or responsibilities regarding a matter relating to anyone who is an applicant or participant in the Continuum of Care Program.

- OR -

☐ I hereby certify that I ***do not*** nor will I have a relationship (by family, marriage or domestic partnership) with any applicant or participant of the above named Program; while an employee of the Service Provider, Los Angeles County Department of Mental Health, who is subcontracted through the Housing Authority of the County of Los Angeles (HACoLA), and has involvement with the file and/or exercises functions or responsibilities regarding matters relating to Continuum of Care Program applicants or participants.

As such, no covered person, meaning a person who is an employee, agent, consultant, officer, or elected or appointed official of the above named service provider and who exercises or has exercised any functions or responsibilities with respect to activities assisted under this program, or who is in a position to participate in a decision-making process or gain inside information with regard to activities assisted under this program, may obtain a financial interest or benefit from an assisted activity, have a financial interest in any contract, subcontract, or agreement with respect to an assisted activity, or have a financial interest in the proceeds derived from an assisted activity, either for him or herself or for those with whom he or she has immediate family or business ties, during his or her tenure or during the one-year period following his or her tenure.

Print Name _____ Title (if applicable) _____

Signature _____ Date _____

Los Angeles County – Department of Mental Health
Countywide Housing, Employment and Education Resource Development
695 South Vermont Avenue, 10th floor, Los Angeles CA 90005

For Office Use	
ID:	

CERTIFICATION
OF
NO CONFLICT OF INTEREST

By signing below, I certify that I am not an officer, employee, or relative of an officer or employee of the Housing Authority of the County of Los Angeles and have no other known conflict of interest.

_____ _____
Print Name – Case Manager Print Name - Client

DMH /_____
Print Agency Name

_____ _____
Signature – Case Manager Date

County of Los Angeles - Department of Mental Health
Countywide Housing, Employment, and Education Resource Development

HOUSING INTAKE AND NEEDS ASSESSMENT

_____
Date of Assessment

Housing History:

What is client's current living situation?

☐ Motel ☐ Board and Care ☐ Streets, car, parks ☐ Transitional residential program
☐ Sober living home ☐ Friends/family ☐ Homeless shelter
☐ Apartment/SRO ☐ Other _____

Specify name or closest street: _____

Length of time in current situation? ☐ 0-3 months ☐ 3-6 months ☐ 6-9 months ☐ 9-12 months ☐ 12 months or longer

How many people does client live with? _____

Who does client live with? _____

Does client share a room? ☐ Yes ☐ No If yes, with whom? _____

Does client pay rent? ☐ Yes ☐ No If yes, how much? _____

Does client have a key? ☐ Yes ☐ No Does client's unit have running water/electricity? ☐ Yes ☐ No

Does client have access to bathroom and cooking facilities? ☐ Yes ☐ No

What kind of agreement does client have to live there? (lease/informal agreement)

_____

Financial Situation:

What is client's total monthly income? _____

Source of Income: ☐ SSI ☐ GR ☐ VA ☐ SSDI ☐ SDI ☐ CALWORKs/TANF
☐ Food Stamps ☐ Child Support ☐ Employment ☐ Other (such as family support)
☐ Unemployment Insurance ☐ None

Is income expected in the future? ☐ Yes ☐ No If yes, how much? _____

Does client have a payee? ☐ Yes ☐ No Does client have a savings/checking account? ☐ Yes ☐ No

Has client ever served in the United States Military? ☐ Yes ☐ No

Is client eligible for Military/Veterans benefits? ☐ Yes ☐ No

Transportation:

Does client own a vehicle? ☐ Yes ☐ No Does client use public transportation? ☐ Yes ☐ No

Criminal Convictions:

	Client:	Other Household Members:	Date of Conviction:
Drug-related?	☐ Yes ☐ No	☐ Yes ☐ No	
Production/manufacture of Methamphetamine?	☐ Yes ☐ No	☐ Yes ☐ No	
Violence-related?	☐ Yes ☐ No	☐ Yes ☐ No	
Registered as a sex offender?	☐ Yes ☐ No	☐ Yes ☐ No	
Arson?	☐ Yes ☐ No	☐ Yes ☐ No	

_____ _____
Print Client Name IS #

DMH /
Agency/Program

Independent Living Supports/Assistance Needed:

Temporary	Ongoing	
☐	☐	Bathing
☐	☐	Care of personal hygiene
☐	☐	Cooking/preparing foods
☐	☐	Laundry
☐	☐	Housekeeping/cleaning
☐	☐	Making/keeping the home safe
☐	☐	Accessing healthcare and medical issues
☐	☐	Grocery shopping
☐	☐	Public/private transportation
☐	☐	Budgeting/banking/money management
☐	☐	Social skills/interpersonal relationships
☐	☐	Exhibiting appropriate behaviors as outlined in lease agreement
☐	☐	Accessing services in crowded places
☐	☐	Paying rent
☐	☐	Maintaining important personal documents and files
☐	☐	Walking a reasonable distance
☐	☐	Ability to wait in line for services
☐	☐	Using public facilities (i.e., post office)

Housing Plan:

How much can client afford to pay in rent? ☐ $0-$300 ☐ $301-$600 ☐ $601-$1,000 ☐ $1,001+

Who will live with the client? _____

_____ Number of minor children _____ Number of adults _____ Number/kind of pets

Does client have a poor credit history? ☐ Yes ☐ No

Does client have financial resources to pay for move-in expenses? ☐ Yes ☐ No

Does client need household furnishings/appliances? ☐ Yes ☐ No

Where does client want to live? Service Area: _____ City: _____

Does anyone in the client's family have physical limitations that would require accommodations? ☐ Yes ☐ No

If yes, what accommodations? _____

Mark all of the following housing situations that client would consider to be acceptable:

Co-Ed environment?	☐ Yes ☐ No	Sharing a unit/room with another family or individual?	☐ Yes ☐ No
Emergency shelter?	☐ Yes ☐ No	Shared or collaborative housing?	☐ Yes ☐ No
DMH Temporary Shelter Program?	☐ Yes ☐ No	Residential drug treatment program?	☐ Yes ☐ No
Sober living home?	☐ Yes ☐ No	Apartment unit/SRO?	☐ Yes ☐ No

In what ways does client need help in locating housing? ☐ Housing referrals ☐ Housing search ☐ Transportation ☐ Completing application ☐ Other _____

Has client ever been evicted from non-subsidized housing? ☐ Yes ☐ No

If yes, how many evictions has client had in the last 10 years? _____

Is client interested in applying for any of the following permanent housing options?

☐ Homeless Section 8 ☐ Shelter Plus Care (SPC) ☐ Section 8 ☐ Project Based Section 8/SPC housing

If yes, complete the questions on the following page:

_____ _____

Print Client Name IS #

DMH / _____

Agency/Program

Shelter Plus Care (SPC) or Homeless Section 8 Eligibility Assessment *(Only Complete If Applicable)*:

Does the client meet HUD homeless criteria (reside in a place not fit for human habitation such as the streets, a park, a car, abandoned buildings, etc., an emergency shelter, transitional housing for clients who originally came from the streets or an emergency shelter, any of these but is spending a short time in a hospital or other institution, residing in a hospital or institution longer than 30 days if there is no discharge plan and the person would be homeless upon discharge, living in a private dwelling and be within one week of a sheriff's eviction with no resources or subsequent residence identified)?

☐ Yes ☐ No

Has the client been HUD homeless for a continuous year or longer? ☐ Yes ☐ No

Has client ever been evicted from a Governmental subsidized housing program (Sec. 8, SPC etc.)? ☐ Yes ☐ No

If client is currently homeless, how many episodes of HUD homelessness has s/he had in the last three years?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

Is client a US citizen or legal resident? ☐ Yes ☐ No

Does client reside in:

A place not meant for human habitation such as the streets, a car, abandoned buildings, parks, bus stations, doorways, etc.? ☐ Yes ☐ No

A homeless shelter? ☐ Yes ☐ No

Transitional or supportive housing for homeless persons who originally came from the streets or a homeless shelter? ☐ Yes ☐ No

Any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution and would otherwise sleep in the types of places described above? ☐ Yes ☐ No

A hospital or institution longer than 30 days if there are no resources available or discharge plan in place and the individual will be homeless when discharged? ☐ Yes ☐ No

A private dwelling and be within one week of a Sheriff's eviction (has eviction papers) with no subsequent residence identified, and lacks the resources and support networks to obtain housing? ☐ Yes ☐ No

Is client fleeing from domestic violence? ☐ Yes ☐ No

Shelter Plus Care is designed for clients who need intensive supportive services such as those in Full Service Partnerships (FSP).

Is the client expected to receive approximately $12,000/yr. worth of ongoing supportive services for at least 5 years? ☐ Yes ☐ No

If the client wants to apply for Homeless Section 8:

Will s/he be receiving supportive services for at least 1 year after lease up? ☐ Yes ☐ No

Is client willing to have at least 4 housing visits in the 1st year of occupancy? ☐ Yes ☐ No

What is the client's housing goal? _____

What have been/are barriers to permanent housing? _____

What are the steps/plan to help client achieve housing goal (include how barriers will be addressed)?

_____

_____

_____

_____

_____ _____

Print Client Name IS #

DMH / _____

Agency/Program

Provider Signature: _____ Client Signature: _____

HMIS Intake and Enrollment Form

Client Name / ID: _____

Identification *- All fields required unless otherwise noted*

HMIS consent? ☐ No (refused) ☐ Written ☐ Verbal (HFSS only) If verbal: Agency_____ Staff_____ Date _____

First Name: _____ **Middle Name** (Optional)**:** _____

Last Name: _____ **Suffix** (Optional)**:** _____

Name Data Quality: Did the client provide their full name?	**Physical Description** (Optional)**:**	**Last Known Permanent Address:** Where have you last lived for 90 days or more? (Not including emergency shelters and transitional housing)
☐ Full Name Reported ☐ Partial, street name, or code name reported ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected		Address: _____ City: _____ County: _____ State: _____ Zip: _____ Address Quality: ☐ Full Address Reported ☐ Incomplete or Estimated Address Reported ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected
Date of Birth:	**SSN:**	
_____/_____/_____ ☐ Full DOB reported ☐ Approximate or partial DOB reported ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	_____-_____-_____ ☐ Full SSN reported ☐ Approximate or partial SSN reported ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	

Contact Information *- Optional but extremely helpful*

Phone Number (*Do you have a number and email where I can follow-up with you or leave a message?)*	**Phone Type**	**Contact Preference**
Main: (_____)_____-_____ x_____ ☐ Leave message	☐ Home ☐ Work ☐ Cell ☐ Message Center	☐ Phone ☐ Text ☐ Email
Alternate:(_____)_____-_____ x_____ ☐ Leave message	☐ Home ☐ Work ☐ Cell ☐ Message Center	
Email _____@_____	**Notes**	

Demographics *- All fields required unless otherwise noted*

Housing Status:		**Family Type:**
☐ Category 1 - Homeless ☐ Category 2 – At Imminent Risk of Losing Housing (within 14 days or less) ☐ Category 3 – Homeless only under other Federal Statutes ☐ Category 4 – Fleeing Domestic Violence ☐ At Risk of Homelessness ☐ Stably Housed	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	☐ Unaccompanied ☐ Single Parent ☐ Two Parents ☐ Adults No children

TB Clearance Date (Optional)	**Clinic Providing Clearance** (Optional)

HMIS Intake and Enrollment Form

Client Name / ID: _____

Relation *(to Head of Household)*	**Gender:**	
☐ Self	☐ Male	☐ Client Doesn't Know
☐ Head of Household's Child	☐ Female	☐ Client Refused
☐ Head of Household's Spouse or Partner	☐ Transgender Female to Male	☐ Data not Collected
☐ Head of Household's other Relation Member	☐ Transgender Male to Female	
☐ Other: Non-relation Member	☐ Doesn't identify as male, female, or transgender	

Disabled? *(Physical, Developmental, Mental Health, Chronic Health Condition, HIV/AIDS, Substance Abuse)*	**Veteran** (Have you ever served in the U.S. Military?)	**Education Level** (What is the highest level of education you've completed?)	
☐ Yes	☐ Yes*	☐ Less than Grade 5	☐ Associate's degree
☐ No	☐ No	☐ Grades 5-6	☐ Bachelor's degree
☐ Client Doesn't Know	☐ Client Doesn't Know	☐ Grades 7-8	☐ Graduate degree
☐ Client Refused	☐ Client Refused	☐ Grade 12 / High school diploma	☐ Vocational certification
☐ Data not Collected	☐ Data not Collected	☐ School program does not have grade levels	☐ Client Doesn't Know
	**If yes, please administer VA release of information*	☐ GED	☐ Client refused
		☐ Some college	☐ Data not collected

Insurance (Health Insurance Provider) (Check all that apply)		**Ethnicity**	**Residency Status**
☐ HealthNet	☐ L.A. Care	☐ Non-Hispanic	☐ Citizen
☐ Anthem Blue Cross	☐ L.A. Care Health Plan	☐ Hispanic	☐ Permanent Legal Resident
☐ Kaiser Permanente	☐ L.A. Care Health Partners	☐ Client Doesn't Know	☐ Asylee, Refugee, or other Eligible Immigrant
☐ VA	☐ Other	☐ Client Refused	☐ Ineligible Immigrant
☐ Care 1st Health Plan	☐ Unknown	☐ Data not Collected	☐ Client Doesn't Know
	☐ None		☐ Client Refused

Race (Check all that apply)				
☐ Asian	☐ Black or African American	☐ Data not Collected ☐ Native Hawaiian or Other Pacific Islander	☐ Client Doesn't Know ☐ American Indian or Alaska Native	☐ Client Refused ☐ White

Income and Insurance *- All fields required unless otherwise noted*

DPSS ID (Optional): _____ ☐ GAIN Participant (Optional)

Income Source (Check all that apply)	**Stated Income**	**Pay Interval**					
		Weekly	Every Other Week	Twice A Month	Monthly	Quarterly	Yearly
☐ No financial resources	$	☐	☐	☐	☐	☐	☐
☐ Earned Income *(employment wages / cash)*	$	☐	☐	☐	☐	☐	☐
☐ Unemployment Insurance	$	☐	☐	☐	☐	☐	☐
☐ Supplemental Security Income (SSI)	$	☐	☐	☐	☐	☐	☐
☐ Social Security Disability Income (SSDI)	$	☐	☐	☐	☐	☐	☐
☐ VA Service-Connected Disability Compensation	$	☐	☐	☐	☐	☐	☐
☐ VA Non-Service-Connected Disability Pension	$	☐	☐	☐	☐	☐	☐
☐ Private Disability Insurance	$	☐	☐	☐	☐	☐	☐
☐ Workers Compensation	$	☐	☐	☐	☐	☐	☐
Continued on Next Page →							

HMIS Intake and Enrollment Form

Client Name / ID: _____

☐ Temporary Assistance for Needy Families *(CalWORKs)*	$	☐	☐	☐	☐	☐	☐	
☐ General Assistance (GA) *(General Relief (GR))*	$	☐	☐	☐	☐	☐	☐	
☐ Retirement Income from Social Security	$	☐	☐	☐	☐	☐	☐	
☐ Pension or retirement income from a former job	$	☐	☐	☐	☐	☐	☐	
☐ Child Support	$	☐	☐	☐	☐	☐	☐	
☐ Alimony or other spousal support	$	☐	☐	☐	☐	☐	☐	
☐ Other Source (Specify:_____)	$	☐	☐	☐	☐	☐	☐	
☐ Client Doesn't Know								
☐ Client Refused								
☐ Data not Collected								

Income Documentation (Optional):

☐ GR Form	☐ CalWORKs Form	☐ Pension Letter/Stub
☐ Pay Stub	☐ Unemployment Insurance Forms	☐ Unemployment Forms
☐ Utility Allowance	☐ W-2 Forms	☐ Self Declaration
☐ Child Support Forms	☐ SSDI Form	☐ Employer Printout/Letter
☐ Social Security Forms	☐ Workmans Comp	☐ VA Documentation
☐ SSI Forms	☐ Self Employment Docs	

Comments (Optional)**:**

Non-Cash Benefits (Check all that apply):

☐ None	☐ Client Doesn't Know	☐ Client Refused	☐ Data not Collected
☐ Food Stamps (CalFresh) Amount: _____	☐ CalWorks Child Care	☐ Temporary Rental Assistance	
	☐ CalWorks Transportation	☐ Section 8 or Rental Assistance	☐ Medically Needy Amount: _____
☐ WIC	☐ Other CalWorks-Funded Services	☐ Other _____	

Health Insurance (Check all that apply)**:**

☐ No Health Insurance		☐ Client Doesn't Know	☐ Client Refused	☐ Data not Collected
☐ Medi-Cal	☐ MEDICARE	☐ State Children's Health	☐ VA Medical Services	☐ Indian Health Services Program
☐ Employer Provided	☐ COBRA	☐ Private Health Insurance		☐ Other: _____

Location Information *- Optional*

Location Type:
On a regular day, where is it easiest to find you?

- ☐ Street
- ☐ Vehicle
- ☐ Abandoned building
- ☐ Bus/train/subway station/airport
- ☐ Drop in center
- ☐ Day services center
- ☐ Soup kitchen
- ☐ Emergency Shelter
- ☐ Transitional Housing
- ☐ Permanent Housing
- ☐ Clinic/Hospital - Health
- ☐ Clinic/Hospital – Mental Health
- ☐ Clinic/Hospital – Substance Abuse
- ☐ Jail, prison, or juvenile detention facility
- ☐ Family or friend's room, apartment, condo, or house
- ☐ Foster care or group home

Address Type
(Enter one: Address, Intersection, or Landmark)**:**

Address: _____

Intersection: _____ and _____

Landmark: _____

City, County, State, and Zip (Enter all)**:**

City: _____

County: _____

State: _____

Zip: _____

Zip Quality: ☐ Full ☐ Client Refused ☐ Client Doesn't Know ☐ Data not Collected

HMIS Intake and Enrollment Form

Client Name / ID: _____

Documentation *- Optional*

Document Type	Obtained Date (If applicable)	Document Status: (If applicable)			Expiration Date (If applicable)
		N/A	Need	Have	
☐ Birth Certificate		☐	☐	☐	
☐ Certificate of Disability		☐	☐	☐	
☐ DD214 (Veterans Only)		☐	☐	☐	
☐ Driver's License / CA ID		☐	☐	☐	
☐ Homeless Verification		☐	☐	☐	
☐ Proof of Residency		☐	☐	☐	
☐ Reference Letter		☐	☐	☐	
☐ Social Security Card		☐	☐	☐	
☐ TB Certification		☐	☐	☐	
☐ Verification of Income		☐	☐	☐	
☐ VA Release		☐	☐	☐	
☐ LACDMH 677 Authorization Consent		☐	☐	☐	
☐ DHS Pre-release		☐	☐	☐	
☐ Other: _____		☐	☐	☐	

Client Note *- Optional*

Client Note:	
Type: ☐ Information ☐ Alert	
Private Customer: ☐ Yes ☐ No	
Note Date: ____/____/____	

Emergency Contact Information *- Optional*

Contact Type	Phone Number	Phone Type	Email
Alternate Contact *(Who is the best person to get in touch with you?)* Relationship: _____ First Name: _____ Last Name: _____	(_____)_____-_____ x_____	☐ Home ☐ Cell ☐ Work ☐ Message Center	
Emergency Contact *(In case of an emergency, who should we alert?)* ☐ Same as above Relationship: _____ First Name: _____ Last Name: _____	(_____)_____-_____ x_____	☐ Home ☐ Cell ☐ Work ☐ Message Center	

Program Entry *- All fields required unless otherwise noted*

Program Name: _____ **Program Entry Date:** _____/_____/_____

Case Manager: _____

HMIS Intake and Enrollment Form

Client Name / ID: _____

HOMELESSNESS – *Adults aged 18 and older and Head of Household < 18 years old, required questions are shaded*

FOR ALL PROJECTS EXCEPT EMERGENCY SHELTER, SAFE HAVEN, AND STREET OUTREACH:

1. What was the situation you were living in immediately prior to project entry? *(Type of residence)*	**2. How long was the client staying in that place?** *(Length of stay in prior living situation)*	**3. Did the client stay less than…**
Literally Homeless Situations ☐ Place not meant for habitation ☐ Emergency shelter, including hotel or motel paid for with emergency shelter ☐ Safe Haven ☐ Interim Housing	***For literally homeless situations:*** ☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused ☐ Data not collected	**Not Applicable** *Go to question 6*
Institutional Situations ☐ Foster care home or foster care group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison or juvenile detention facility ☐ Long-term care facility or nursing home ☐ Psychiatric hospital or other psychiatric facility ☐ Substance abuse treatment facility or detox center	***For institutional situations:*** ☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused ☐ Data not collected	***90 days:*** ☐ Yes *Go to question 6* ☐ No *Go to question 10*
Transitional & Permanent Housing Situations ☐ Hotel or motel paid for without emergency shelter voucher ☐ Owned by client, no ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Permanent housing for formerly homeless persons ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with VASH subsidy ☐ Rental by client, with GPD TIP subsidy ☐ Rental by client, with other ongoing housing subsidy ☐ Residential project or halfway house with no homeless criteria ☐ Staying or living in a family member's room, apartment or house ☐ Staying or living in a friend's room, apartment or house ☐ Transitional housing for homeless persons (including homeless youth) ***Other*** ☐ Client doesn't know ☐ Client refused ☐ Data not collected	***For transitional & permanent housing situations:*** ☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused ☐ Data not collected	***7 nights:*** ☐ Yes *Go to question 6* ☐ No *Go to question 10*

HMIS Intake and Enrollment Form

Client Name / ID: _____

FOR EMERGENCY SHELTER, SAFE HAVEN, AND STREET OUTREACH PROJECTS:

Question	Check One Answer	Comments
4. What was the situation you were living in immediately prior to project entry? *(Type of residence)*	☐ Place not meant for habitation ☐ Emergency shelter, including hotel or motel paid for with emergency shelter ☐ Safe Haven ☐ Interim Housing ☐ Foster care home or foster care group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison or juvenile detention facility ☐ Long-term care facility or nursing home ☐ Psychiatric hospital or other psychiatric facility ☐ Substance abuse treatment facility or detox center ☐ Hotel or motel paid for without emergency shelter voucher ☐ Owned by client, no ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Permanent housing for formerly homeless persons ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with VASH subsidy ☐ Rental by client, with GPD TIP subsidy ☐ Rental by client, with other ongoing housing subsidy ☐ Residential project or halfway house with no homeless criteria ☐ Staying or living in a family member's room, apartment or house ☐ Staying or living in a friend's room, apartment or house ☐ Transitional housing for homeless persons (including homeless youth) ☐ Client doesn't know ☐ Client refused ☐ Data not collected	
5. How long was the client staying in that place? *(Length of stay in prior living situation)*	☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused ☐ Data not collected	

After asnwering question 5, go to question 7

If the client is coming from an institution after having stayed less than 90 days or if the client is coming from a transitional, permanent, or other situation after having stayed less than 7 nights, then the following question is required:

Question	Check One Answer	Comments
6. On the night before your current housing situation, did you stay on the streets, in an emergency shelter, or at a safe haven?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	

If the project being entered is an emergency shelter, safe haven, or street outreach, or if the client answered questions #4 and #5, then the following questions are required:

Question	Check One Answer	Comments
7. What approximate date did you start living on the streets, emergency shelter, or safe haven? *(Approximate date started)*	_____/_____/_____	

HMIS Intake and Enrollment Form

Client Name / ID: _____

8. In the past three years, how many times have you returned to the streets, an emergency shelter, or a safe haven after being housed? *(Number of times the client has been on the streets, in ES, or SH in the past three years including today)*	☐ One Time ☐ Two Times ☐ Three Times ☐ Four or more times		☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected
9. In those three years, what is the total number of months spent homeless on the streets, in an emergency shelter, or in a safe haven? *(Total number of months homeless on the street, in ES, or SH in the past three years)*	☐ One Month (this time is the first month) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6	☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ More than 12 months	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected

Continue for all clients:

WELLNESS *– All clients, required questions are shaded*

Question	Check One Answer		Comments
10. Have you been diagnosed with AIDS or have you tested positive for HIV?	☐ No ☐ Yes*	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #10 was answered as "Yes" (*), then the following questions are **required**:			
10a. Do you expect this to substantially impair your ability to live independently?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
10b. Do you have documentation of the disability and severity on file?	☐ No ☐ Yes		
10c. Are you currently receiving services or treatment for this condition?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
11. Do you have a chronic health condition? *A Chronic Health Condition is defined as a diagnosed condition that is more than 3 months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples of chronic health conditions include, but are not limited to:* ***heart disease*** *(including coronary heart disease, angina, heart attack and any other kind of heart condition or disease);* ***severe asthma****; diabetes;* ***arthritis-related conditions*** *(including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia);* ***adult onset cognitive impairments*** *(including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions);* ***severe headache/migraine****;* ***cancer****;* ***chronic bronchitis****;* ***liver condition; stroke****; or* ***emphysema****.*	☐ No ☐ Yes*	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #11 was answered as "Yes" (*), then the following questions are **required**:			
11a. Is this temporary, or do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
11b. Do you have documentation of the disability and severity on file?	☐ No ☐ Yes		
11c. Are you currently receiving services or treatment for this condition?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	

HMIS Intake and Enrollment Form

Client Name / ID: _____

12. Do you have a physical disability?	☐ No ☐ Yes*	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #12 was answered as "Yes" (*), then the following questions are **required**:			
12a. Is this temporary, or do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
12b. Do you have documentation of the disability and severity on file?	☐ No ☐ Yes		
12c. Are you currently receiving services or treatment for this condition?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
13. Do you *currently* have a drug or alcohol problem?	☐ No ☐ Alcohol* ☐ Drug* ☐ Both*	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #13 was answered as "Alcohol", "Drug", or "Both" (*), then the following questions are **required**:			
13a. Is this temporary, or do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
13b. Do you have documentation of the disability and severity on file?	☐ No ☐ Yes		
13c. Are you currently receiving services or treatment for this condition?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
14. Have you ever been told you have a learning disability or developmental disability?	☐ No ☐ Yes*	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #14 was answered as "Yes" (*), then the following questions are **required**:			
14a. Is this temporary, or do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
14b. Do you have documentation of the disability and severity on file?	☐ No ☐ Yes		
14c. Are you currently receiving services or treatment for this condition?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
15. Do you feel you currently have a mental health problem?	☐ No ☐ Yes*	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #15 was answered as "Yes" (*), then the following questions are **required**:			
15a. Is this temporary, or do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
15b. Do you have documentation of the disability and severity on file?	☐ No ☐ Yes		
15c. Are you currently receiving services or treatment for this condition?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	

16. Have you been a victim of domestic violence or a victim of intimate partner violence?	☐ No ☐ Yes* ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #16 was answered as "Yes" (*), then the following question is **required**:		
16a. How long ago did you have this experience?	☐ Within the past three months ☐ Three to six months ago (excluding six months exactly) ☐ From six to twelve months ago (excluding one year exactly) ☐ More than a year ago ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
16b. Are you currently fleeing?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	

TUBERCULOSIS *– Emergency Shelters and Winter Shelters only, required questions shaded*

Question	Check One Answer	Comments
17. Do you have a cough that has lasted longer than 3 weeks?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused	
18. Have you recently lost weight without explanation during the past month?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused	
19. Have you had frequent night sweats during the past month, soaking your sheets or clothing?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused	
20. Have you coughed up blood in the past month?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused	
21. Have you been feeling much more tired than usual over the past month?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused	
22. Have you had fevers almost daily for more than one week?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused	

EMPLOYMENT *- For adults18 and older or Head of Household < 18 years old, required questions shaded*

Question	Check One Answer	Comments
23. Are you currently employed?	☐ No* ☐ Yes** ☐ Client Doesn't Know ☐ Client Refused	
If question #23 was answered as "No" (*), then the following question is **required**:		
23a. Why are you not employed?	☐ Looking for work ☐ Unable to work ☐ Not looking for work	
If question #23 was answered as "Yes" (**), then the following question is **required**:		
23b. What type of employment do you have?	☐ Full-time ☐ Part-time ☐ Seasonal / sporadic (including day labor)	

HMIS Intake and Enrollment Form

Client Name / ID: _____

INCOME *- Adults aged 18 and older having* ***NO*** *financial resources only*

Question	Check One Answer		Comments
24. If you do not have an income, and are unable to receive general relief, what's the reason why?	☐ Sanctioned ☐ Time Limits ☐ Employment	☐ Other	

PREGNANCY *- Women aged 15 and older only*

Question	Check One Answer		Comments
25. Are you pregnant?	☐ No ☐ Yes*	☐ Client Doesn't Know ☐ Client Refused	
If question #25 was answered as "Yes" (*), then the following question is **required**:			
25a. What is your due date?	____/____/_____		

YOUTH *- Head of Households aged 17 and under only*

Question	Check One Answer		Comments
26. Did you run away from home or a foster care home?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused	

TRANSITION AGE YOUTH (TAY) *- Head of Households aged 16 to 24 only, required questions are shaded*

Question	Check One Answer		Comments
27. Are you a current or former foster care youth?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused	
28. Have you ever been in the juvenile justice system?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused	
29. Have you ever been on adult probation?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused	
30. Which of the following best represents how you think about yourself?	☐ Straight ☐ Lesbian or Gay ☐ Bisexual	☐ Questioning ☐ Client Doesn't Know ☐ Client Refused	

HMIS Intake and Enrollment Form

Client Name / ID: _____

VETERAN *- US Veterans only, required questions are shaded*

Question	Check One Answer	Comments
31. Which branch of the military did you serve in?	☐ Army ☐ Coast Guard ☐ Air Force ☐ Client Doesn't Know ☐ Navy ☐ Client Refused ☐ Marines ☐ Data not Collected	
32. What type of discharge did you receive?	☐ Honorable ☐ General under honorable conditions ☐ Other than honorable conditions (OTH) ☐ Bad Conduct ☐ Dishonorable ☐ Uncharacterized ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
33. When did you enter military service?	____/____/_____ ☐ Doesn't Know	

NOTE: The following questions are required for SSVF programs, but HIGHLY recommended to be completed for all veterans.

34. When did you separate from military service?	____/____/_____ ☐ Doesn't Know	
35. What is the AMI percentage for the Household's Income?	☐ Less than 30% ☐ 30% to 50% ☐ Greater than 50%	

Did you serve in any of the following wars/war eras?

36. World War II *Dec. 1941 – Dec. 1946*	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused ☐ Data not Collected	
37. Korean War *Jun. 1950 – Jan. 1955*	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused ☐ Data not Collected	
38. Vietnam War *Feb. 1961 – May 1975*	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused ☐ Data not Collected	
39. Persian Gulf War (Operation Desert Storm) *Aug. 1990 – April 1991*	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused ☐ Data not Collected	
40. Afghanistan (Operation Enduring Freedom) *Oct. 2001 - Present*	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused ☐ Data not Collected	
41. Iraq (Operation Iraqi Freedom) *Mar. 2003 – Aug. 2010*	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused ☐ Data not Collected	
42. Iraq (Operation New Dawn) *Sept. 2010 – Dec. 2011*	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused ☐ Data not Collected	
43. Other Peace-keeping Operations or Military Interventions (such as Lebanon, Panama, Somalia, Bosnia, Kosovo)	☐ No ☐ Client Doesn't Know ☐ Yes ☐ Client Refused ☐ Data not Collected	

HMIS Intake and Enrollment Form

Client Name / ID: _____

SSVF HP TARGETING CRITERIA *- US Veterans only, required for SSVF Prevention programs*

44. Referred by Coordinated Entry or a homeless assistance provider to prevent the household from entering an emergency shelter or transitional housing or from staying in a place not meant for human habitation.

☐ No (0 points) ☐ Yes

45. Major change in household composition (e.g., death of family member, separation/divorce from adult partner, birth of new child) in the past 12 months

☐ No (0 points) ☐ Yes

46. Rental Evictions within the Past 7 Years

☐ 4 or more prior rental evictions ☐ 2-3 prior rental evictions ☐ 1 prior rental eviction ☐ No prior rental evictions (0 points)

47. Currently at risk of losing a tenant-based housing subsidy or housing in a subsidized building or unit

☐ No (0 points) ☐ Yes

48. History of Literal Homelessness (street/shelter/transitional housing)

☐ 4 or more times or total of at least 12 months in past three years ☐ 2-3 times in past three years
☐ 1 time in past three years ☐ None (0 points)

49. Head of household with disabling condition (physical health, mental health, substance use) that directly affects ability to secure/maintain housing

☐ No (0 points) ☐ Yes

50. Criminal record for arson, drug dealing or manufacture, or felony offense against persons or property

☐ No (0 points) ☐ Yes

51. Registered sex offender

☐ No (0 points) ☐ Yes

52. At least one dependent child under age 6

☐ No (0 points) ☐ Yes

53. Single parent with minor child(ren)

☐ No (0 points) ☐ Yes

54. Household size of 5 or more requiring at least 3 bedrooms (due to age/gender mix)

☐ No (0 points) ☐ Yes

55. Any Veteran in household served in Iraq or Afghanistan

☐ No (0 points) ☐ Yes

56. Female Veteran

☐ No (0 points) ☐ Yes

57. HP applicant total points

58. Grantee targeting threshold score

USE OF OTHER CRISIS SERVICES *- US Veterans only, required for SSVF programs*

59. Number of visits to an emergency room in the past year

☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ 11-20 ☐ More than 20 ☐ Client Doesn't Know ☐ Client refused ☐ Data not collected

60. Approximate number of nights in jail / prison in the past year

☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ 11-20 ☐ More than 20 ☐ Client Doesn't Know ☐ Client refused ☐ Data not collected

61. Approximate number of nights spent in an inpatient medical facility in the past year

☐ Never ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ 11-20 ☐ More than 20 ☐ Client Doesn't Know ☐ Client refused ☐ Data not collected

HMIS Intake and Enrollment Form

Client Name / ID: _____

CHRONIC HOMELESSNESS *- Adults aged 18 and older and Head of Household < 18 years old, required questions are shaded*

Question	Check One Answer	Comments
ASSESSOR ONLY – DO NOT ASK: **44.** Is the respondent chronically homeless? *To be chronically homeless, the client must be an unaccompanied homeless individual with a disabling condition or a family with at least one adult member who has a disabling condition who has either been continuously homeless* for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years. To be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency shelter during that time.*	☐ No ☐ Yes	

_____ _____ _____

Client Signature Site Date

_____ _____ _____

Agency Staff Signature Site Date

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

I authorize the use and disclosure of my protected health information (PHI) as described below:

CLIENT/INDIVIDUAL IDENTIFICATION

First Name _____ **Last Name** _____

Street Address _____ **City, State, Zip** _____

IS Number _____ **Birth Date** _____ **Phone Number** ( )_____

DISCLOSING PARTY - RECIPIENT OF PHI

This authorization allows: Department of Mental Health to use and/or to disclose my PHI, as described below, to the Los Angeles & Orange County Homeless Management Information System (LA/OC HMIS).

REDISCLOSURE NOTICE:

I understand that my PHI which is used or disclosed pursuant to this Authorization may no longer be protected by Federal Law and could be further used or disclosed by the recipient without my authorization. I also understand that once my information is disclosed, it may not be possible to retrieve.

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Disclosed:

Information contained in the Section 8 Special Programs application such as verification of disability, demographics, financial information, current and previous addresses, social security number, proof of citizenship/legal residency, employment information and any additional information that would assist an individual/family to obtain housing. Also, any information required to maintain housing such as frequency, type and financial value of services.

Purpose of Disclosure:

My PHI may be used for determination of eligibility for the Section 8 Special Program, assistance with locating and/or maintaining housing, and to meet all of the requirements of the housing program such as entering information into the LA/OC HMIS managed by the Los Angeles Homeless Services Authority. This information will also be used to coordinate services and track client information.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

Neither LACDMH nor any person signing this Authorization will receive any direct or indirect remuneration.

N O T I C E

COPY OF THIS AUTHORIZATION: I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

CONDITIONS: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment.

LACDMH will not take any intimidating or retaliatory acts against anyone who does not wish to disclose their PHI or sign this Authorization.

EXPIRATION DATE

Expiration Date: This authorization remains valid until the Section 8 Special Program participant is no longer receiving housing subsidy services through Department of Mental Health's grant with City and/or Housing Authorities.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so:

REVOCATION OF AUTHORIZATION: I understand that I have the right to revoke this authorization at any time in writing. I may use the Revocation of Authorization Section of this form, mail or deliver the revocation to LAC-DMH Countywide Housing, Employment, and Education Resource Development Federal Housing Subsidies Unit, 695 S. Vermont Ave., 10th Floor, Los Angeles, CA 90005. I also understand that a revocation will be effective upon receipt, but will not be effective as to uses and/or disclosures of my protected health information already made in reliance on this Authorization.

REVOCATION OF AUTHORIZATION

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so:

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

I authorize the use and disclosure of my protected health information (PHI) as described below:

CLIENT/INDIVIDUAL IDENTIFICATION

First Name	**Last Name**
Street Address	**City, State, Zip**
IS Number	**Birth Date**
	( ) Phone Number

DISCLOSING PARTY - RECIPIENT OF PHI

This authorization allows: Department of Mental Health to use and/or to disclose my PHI, as described below, to the Housing Authority of the County of Los Angeles (HACoLA), Special Needs Housing Unit.

REDISCLOSURE NOTICE:

I understand that my PHI which is used or disclosed pursuant to this Authorization may no longer be protected by Federal Law and could be further used or disclosed by the recipient without my authorization. I also understand that once my information is disclosed, it may not be possible to retrieve.

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Disclosed:

Information contained in HACoLA's housing subsidy application such as verification of disability, demographics, financial information, current and previous addresses, social security number, proof of citizenship/legal residency, employment information and any additional information that would assist an individual/family to obtain housing. Also, any information required to maintain housing such as frequency, type and financial value of services.

Purpose of Disclosure:

My PHI may be used for determination of eligibility for housing subsidies assistance, with locating and/or maintaining housing, and to meet all of the requirements of the housing program such as providing quarterly and annual reports.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

Neither LACDMH nor any person signing this Authorization will receive any direct or indirect remuneration.

N O T I C E

COPY OF THIS AUTHORIZATION: I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

CONDITIONS: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment.

LACDMH will not take any intimidating or retaliatory acts against anyone who does not wish to disclose their PHI or sign this Authorization.

EXPIRATION DATE

Expiration Date: This authorization remains valid until the housing subsidies program participant is no longer receiving services through Department of Mental Health's grant with HACoLA.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so:

REVOCATION OF AUTHORIZATION: I understand that I have the right to revoke this authorization at any time in writing. I may use the Revocation of Authorization Section of this form, mail or deliver the revocation to LAC-DMH Countywide Housing, Employment, and Education Resource Development Federal Housing Subsidies Unit, 695 S. Vermont Ave., 10th Floor, Los Angeles, CA 90005. I also understand that a revocation will be effective upon receipt, but will not be effective as to uses and/or disclosures of my protected health information already made in reliance on this Authorization.

REVOCATION OF AUTHORIZATION

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so:

LAC-DMH NOTICE OF PRIVACY PRACTICES: *Acknowledgement of Receipt* Effective Date: September 23, 2013

TRANSLATION ☐ NO ☐ YES

This Acknowledgement was translated into _____ for the client and /or responsible adult*

_____ _____
PRINT NAME OF TRANSLATOR DATE

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Los Angeles County - Department of Mental Health (LAC-DMH). Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to review it carefully.

Our *Notice of Privacy Practices* is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website at http://dmh.lacounty.gov/ or on request from our Treatment Team.

I acknowledge receipt of the *Notice of Privacy Practices* of LAC-DMH**.**

Signature: _____ Date:_____
(Client/Responsible Adult)

*Responsible Adult = Guardian, Conservator, or Parent of Minor when required (See Minor Consent)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of Treatment Team Member:_____ Date:_____

Reasons why the acknowledgement was not obtained:

- ☐ Client refused to sign (see progress notes for explanation)
- ☐ Other Reason or Comments:

_____

_____

_____

_____

_____

_____

Los Angeles County –Department of Mental Health
Notice of Privacy Practices

Effective: **September 23, 2013**

NOTICE OF PRIVACY PRACTICES (NPP)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING /PROTECTED HEALTH INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting your information. We refer to this information as "Protected Health Information" or "PHI". We create a record of the care and services you receive from Los Angeles County-Department of Mental Health ("LAC-DMH"). We need this record to provide you with quality care and to comply with certain legal and payment requirements.

This notice will tell you about the ways in which we may use and disclose your PHI. We also describe your rights and certain obligations we have regarding the use and disclosure of PHI. We are required by law to:

- make sure that PHI that identifies you is kept private;
- give you this notice of our legal duties and privacy practices concerning your PHI; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE PHI ABOUT YOU

We use and disclose PHI in many ways. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories required by law.

For Treatment We may use PHI about you to provide you with medical treatment or services. We may disclose PHI about you to doctors, nurses, technicians, nursing and medical students, or LAC-DMH personnel who are involved in taking care of you. For example, a doctor treating you for a chemical imbalance may need to know if you have problems with your heart because some medications may affect your blood pressure. We may share your PHI for treatment in order to coordinate the different things you need, such as prescriptions, blood pressure checks and lab tests, and to determine a correct diagnosis.

For Payment We may use and disclose PHI about you so that the treatment and services you receive at LAC-DMH may be billed and payment may be collected from you or on your behalf from an insurance company or a third party. For example, we may need to give your health plan information about testing that you received at our facilities so your health plan will pay us or reimburse you for those services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations We may use and disclose PHI about you for our LAC-DMH business operations. These uses and disclosures are necessary to run our organization and make sure that all of our patients receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also gather PHI about many of LAC-DMH clients to decide what additional services our facilities should offer, what

services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, nursing and medical students, and other personnel for review and learning purposes. We may also compare the PHI we have with PHI from other organizations and providers to determine how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of PHI so others may use it to study health care and health care delivery without learning the identify of any clients.

For Appointment Reminders We may use and disclose PHI to contact you as a reminder that you have an appointment for treatment or medical care at LAC-DMH clinics.

For Your Own Information We may use and disclose PHI to tell you about your own health condition, such as your test results, to tell you about or recommend possible treatment options or alternatives, and to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care We may disclose PHI about you to a family member or other person you designate if you give us permission to do so. We may also tell certain family members about your presence in our facility but only if the law permits us to do so. We may share PHI about you when necessary for a claim for aid, insurance, or medical assistance to be made on your behalf.

For Health Information Exchange (HIE)We, along with other health care providers in the Los Angeles area, participate in one or more health information exchanges. An HIE is a community-wide information system used by participating health care providers to share health information about you for treatment purposes. Should you require treatment from a health care provider that participates in one of these exchanges who does not have your medical records or health information, that health care provider can use the system to gather your health information in order to treat you. For example he or she may be able to get laboratory or other tests that have already been performed or find out about the treatment that you have already received. We will include your PHI in this system.

For Research

Under certain circumstances, we may use and disclose PHI about you for research purposes. For example, a research project may involve comparing the health and recovery of all clients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of PHI, trying to balance the research needs with patients' need for privacy of their PHI. Before we use or disclose PHI for research, the project will have been approved through this research approval process, but we may, disclose PHI about you to people preparing to conduct a research project, for example, to help them look for clients with specific medical needs. We will always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care.

As Required By Law We will disclose PHI about you when required to do so by federal, State or local law, such as laws that require us to report abuse.

To Avert a Serious Threat to Health or Safety We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

To Provide Breach Notification We may use and disclose your PHI, if necessary, to tell you and regulatory authorities or agencies of unlawful or unauthorized access to your PHI. For example, if your PHI is lost or stolen.

SPECIAL SITUATIONS WHEN WE MAY USE OR DISCLOSE PHI/PHI ABOUT YOU:

Workers' Compensation We may release PHI about you for workers' compensation or similar programs to comply with these and other similar legally established programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks We may disclose PHI about you when required for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of product recalls of the products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a client has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect We may disclose PHI about you to a public health authority that is authorized by law to receive reports of child abuse or neglect. We may also disclose your PHI if we believe that you have been a victim of elder or dependent adult abuse or neglect provided the disclosure is authorized by law.

Lawsuits and Dispute If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the privacy of the information requested.

Law Enforcement We may release PHI if asked to do so by a law enforcement official:

- in response to a court order, court-issued subpoena, court- issued warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's authorization;
- about criminal conduct at LAC-DMH facilities; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities as required by law.

Protective Services for the President and Others We may disclose PHI about you to authorized federal or government law enforcement officials so they may provide protection to the President, other authorized or elected persons or foreign heads of state or to conduct special investigations.

Protection and Advocacy Services We may disclose PHI about you to the protection and advocacy agency established by law to investigate incidents of abuse and neglect and to otherwise protect the legal and civil rights of people with disabilities.

Inmates If you are an inmate of a correctional institution or under the custody of a law enforcement official we may disclose PHI about you to the correctional institution or law enforcement official. This disclosure would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING PHI ABOUT YOU

You have the following rights regarding PHI we maintain about you:

Right to Inspect and Copy You have the right to inspect and copy your PHI that is used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing to the facility where you are receiving treatment/services. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. If your health information is available electronically, under certain circumstances, you may be able to obtain this information in an electronic format. We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to PHI, you may request, in writing, that the denial be reviewed. Another licensed health care professional chosen by LAC-DMH will review your request and the denial. The person conducting the review will not be the person who previously denied your request. We will comply with the outcome of the review.

Right to Amend If you feel that PHI we have about you is incorrect or incomplete, you may ask us to include additional information in your medical record. You have the right to request an amendment for as long as all of the information, both old and new, is kept by or for LAC-DMH. To request an amendment, your request must be made in writing and submitted to the LAC-DMH facility where the information is in question. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

- is not part of the PHI kept by LAC-DMH;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of PHI about you, excluding disclosures for the purpose of treatment, payment or healthcare operations. To request this list or accounting of disclosures, you must submit your request in writing to LAC-DMH or we will provide you with a form to make your request. Your request must state a time period, which may not be more than six years prior to your request. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12- month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member. We will do our best to honor your request; however, except when you fully pay out-of-pocket as explained below, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing or we will provide you with a form to make your request. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right To Restrict Disclosure of Information For Certain Services You have the right to restrict the disclosure of information regarding services for which you or someone else has paid in full or on an out-of-pocket basis (in other words you don't ask us to bill your health plan or health insurance company). If you or someone else has paid in full for a service, we must agree to your request and we will not share this information with your health plan without your written authorization, unless the law requires us to share your information.

Right to Request Confidential Communication You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to LAC-DMH or we will provide you with a form to make your request. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must tell us how or where you wish to be contacted. If you do not tell us how or where you wish to be contacted, we do not have to honor your request.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, ask any of our office staff. You may obtain a copy of this Notice at our website: http://dmh.lacounty.gov/

OTHER USES OF PHI

Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose PHI about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice. We reserve the right to make the revised or changed Notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the facility. The Notice will contain on the first page, in the top right-hand corner, the effective date. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website at http://dmh.lacounty.gov/ or you may request one from one of our facilities.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us, Los Angeles County or the U.S. Department of Health & Human Services. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint. To file a complaint with us, or if you have comments or questions regarding our privacy practices, please contact:

Los Angeles County Department of Mental Health (LAC-DMH)
Patients' Rights Division
550 South Vermont Avenue
Los Angeles, CA 90020
(213) 738-4949

To file a complaint with Los Angeles County, contact:

Los Angeles County Auditor-Controller
HIPAA Compliance Unit
500 West Temple Street, Suite 515
Los Angeles, CA 90012
(213) 974-2164
Email: HIPAA@auditor.lacounty.gov

To file a complaint with the Federal Government, contact:

Region IX, Office for Civil Rights,
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Voice Phone (415) 437-8310
FAX (415) 437-8329
TDD (800) 537-7697

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

COUNTYWIDE HOUSING, EMPLOYMENT & EDUCATION RESOURCE DEVELOPMENT

SHELTER PLUS CARE PROGRAM
SERVICE PROVIDER RESPONSIBILITY FORM

To be completed and signed by the Program/Agency Manager:

Name of Participant: _____

Name of Agency: DMH / _____

The program manager will ensure that the Shelter Plus Care (SPC) participant will have an assigned case manager who will be responsible for the following for the duration of client participation in the program:

- Assist the client with completing the required documents by the Housing Authority of the City of Los Angeles (HACLA) or Housing Authority of the County of Los Angeles (HACoLA) and accompany the participant to the scheduled meetings with Housing Authorities.

- Assist the client in a housing search.

- Send signed lease agreements to the Federal Housing Subsidies Unit (FHSU) when received.

- Ensure that the agency remains updated regarding participant's current contact information.

- Maintain, at a minimum, monthly contact with the participant and quarterly home visits.

- Conduct needs assessments to determine appropriate linkage to community-based services such as health care, childcare, alcohol and other substance abuse, education and/or job training, and other services essential for achieving and maintaining independent living.

- Conduct ongoing assessments/evaluations to monitor progress and provide appropriate interventions as needed.

- Provide a Housing Annual Assessment form that incorporates the current housing goal to ensure compliance with housing contracts between DMH and the Housing Authorities. This should be submitted to FHSU each year on the anniversary of the lease up date.

- Update the participant's Client Care Coordination Plan (CCCP) annually and include any appropriate housing-related goals.

- Submit signed MH 677, Authorizations for Request and Use/Disclosure of Protected Health Information (PHI) to allow DMH to disclose PHI to the Housing Authority (MH 677 HACLA or MH 677 HACoLA) and to the Los Angeles Homeless Services Authority/Homeless Management Information System (MH 677 HMIS), and a signed MH 601E, Acknowledgement of Receipt of the LACDMH Notice of Privacy Practices.

- Comply with all requirements of McKinney Vento's Homeless Assistance Act (42 U.S.C. 11431 et seq.) including that they ensure and monitor that households with school-aged minors are enrolled in school and receive entitled benefits.

- Complete all required reports and any other requested documentation including the Quarterly Report Survey (HACLA) and Client Progress Report - Quarterly Review (HACoLA). These records will be subject to audit by HUD and the local Housing Authority administering the grant.

- Participate in regularly scheduled Housing Liaison meetings to obtain updates on program requirements.

- Assist the client with completing his/her paperwork for the Annual Recertification Packet (HACLA) or Annual Re-exam Packet (HACoLA).

- If the participant is transferred to another directly-operated or contracted DMH agency/program, ensure that the new program is aware that the client is a SPC participant and that they understand the requirements of the program by gaining the signature of the new Program Manager on the Service Provider Responsibility form and submitting it to FHSU.

- Notify FHSU if the participant abandons his/her unit, is deceased, or terminated from SPC.

Print Program/Agency Manager's Name: _____

Program/Agency Manager's Signature: _____

Date: _____

Authorization to Release Information

CLIENT #: _____

I authorize the Housing Authority of the County of Los Angeles (HACoLA) to release any requested information, to provide copies of any documents contained in my file, and to discuss any topic relevant to my application for or participation in a HACoLA assisted housing program with the following and their agents or employees. This authorization form is valid throughout the duration of my participation in the HACoLA assisted housing program.

☐ Los Angeles County Department of Mental Health

☐ Other (please name): _____

Client's Name: _____

Client's Signature: _____

Date: _____

(04/2016)

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

SHELTER PLUS CARE PARTICIPANT AGREEMENT

As a participant in the Shelter Plus Care (SPC) Program with the Housing Authority of the City of Los Angeles (HACLA) or Housing Authority of the County of Los Angeles (HACoLA), **I agree to abide by the following program expectations**:

1. Maintain contact and meet, as necessary, with my case manager at a minimum of once monthly for as long as I am a participant in the SPC Program.
2. Participate in the development of the Client Coordination Care Plan (CCCP) with my service provider team to pursue my recovery goals.
3. Participate in supportive services to pursue my recovery goals including vocational and educational assistance, life skills classes, budget and money management classes, nutritional planning, and any other supportive services as deemed necessary.
4. Receive quarterly home visits from my service provider team.
5. Abide by the terms of my lease agreement.
6. Provide a signed lease agreement to my service provider team in a timely manner.
7. Provide my service provider team with updated contact information (phone number, address, emergency contact. etc).
8. If applicable, provide my service provider team with information about any school-aged minors in my household and whether they are enrolled in school and receiving entitled benefits so that DMH can be in compliance w/ McKinney Vento's Homeless Assistance Act (42 U.S.C. 11431 et seq.).
9. _____
   _____
10. _____
    _____

Print Client's Name: _____

Client's Signature: _____ Date: _____

Case Manager's Signature: _____ Date: _____

Translated by: _____ Date: _____

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

COUNTYWIDE HOUSING, EMPLOYMENT & EDUCATION RESOURCE DEVELOPMENT

AFFORDABLE CARE ACT CERTIFICATION FORM

To be completed and signed by the Case Manager:

Our agency / program certifies that we are ensuring this program participant is assisted in applying for ACA Health Benefits, if appropriate (or officially opting out) and maintaining documentation indicating if the assistance was provided and completed on-site or if a referral was made to an off-site agency.

☐ Check here if participant already has health insurance such as Medi-Cal or Medicare

Name of Participant: _____

Name of Agency: DMH / _____

Print Case Manager's Name: _____

Case Manager's Signature: _____

Date: _____

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

JONATHAN E. SHERIN, M.D., Ph.D., Director
ROBIN KAY, Ph.D., Chief Deputy Director
RODERICK SHANER, M.D., Medical Director

ACKNOWLEDGEMENT OF RECEIPT
MCKINNEY-VENTO ACT HOMELESS EDUCATION RIGHTS

According to the McKinney-Vento Act, children have the right to:

- Go to school, even if they do not have a permanent address
- Immediate enrollment, even if missing records and documents normally required for enrollment
- Attend the school attended immediately prior to becoming a family or youth that became homeless, if at all possible (taking shelter resources and domestic violence situations into consideration)
- Have access to the same services and programs that are available to all other students
- Receive transportation to school from their current residence
- Automatically be enrolled in free lunch or free meal programs

The following resources can assist you to access educational benefits for your family:

Los Angeles County Office of Education Website:
http://www.lacoe.edu/StudentServices/HomelessFosterYouth/HomelessChildren

Los Angeles County Office of Education Contact
Melissa Schoonmaker
School Attendance Review Board/McKinney-Vento Homeless Education Program Manager
Email: homeless_program@lacoe.edu
Phone: (562) 922-6233 Fax: (562) 922-6781
Student Support Services - Education Center West (formerly Clark)
12830 Columbia Way, ECW-3236, Downey, CA 90242

Los Angeles Unified School District (LAUSD):

LAUSD Web site
http://homelesseducation.lausd.net/

LAUSD Contact
Angela Chandler, Pupil Service and Attendance Coordinator
Phone: (213) 202-7581 Fax: (213) 580-6551
LAUSD Homeless Education Program, Roybal Annex
121 N. Beaudry Ave.
Los Angeles, CA 90012

Please refer to the attached bulletin from the California Department of Education for additional information.

I acknowledge receiving this notice and the attached bulletin: _____
Print Name

_____ _____
Signature Date

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

JONATHAN E. SHERIN, M.D., Ph.D., Director
ROBIN KAY, Ph.D., Chief Deputy Director
RODERICK SHANER, M.D., Medical Director

NOTICE TO HOUSEHOLDS WITH SCHOOL-AGE YOUTH
MCKINNEY-VENTO ACT HOMELESS EDUCATION RIGHTS

According to the McKinney-Vento Act, children have the right to:

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- Immediate enrollment, even if missing records and documents normally required for enrollment
- Attend the school attended immediately prior to becoming a family or youth that became homeless, if at all possible (taking shelter resources and domestic violence situations into consideration)
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Phone: (213) 202-7581 Fax: (213) 580-6551
LAUSD Homeless Education Program, Roybal Annex
121 N. Beaudry Ave.
Los Angeles, CA 90012

Please refer to the attached bulletin from the California Department of Education for additional information.

You can ENROLL in school!

Even if you have:

- **Uncertain housing**
- **A temporary address**
- **No permanent physical address**

You are guaranteed enrollment in school by the federal McKinney-Vento Act and California state law if you live:

- In a shelter (family, domestic violence, or youth shelter or transitional living program)
- In a motel, hotel, or weekly rate housing
- In a house or apartment with more than one family because of economic hardship or loss
- In an abandoned building, in a car, at a campground, or on the street
- In temporary foster care or with an adult who is not your parent or guardian
- In substandard housing (without electricity, water, or heat)
- With friends or family because you are a runaway or an unaccompanied youth

To enroll in or attend school if you live under any of these conditions, you do NOT need to provide:

- Proof of residency
- Immunization records or tuberculosis skin-test results
- School records
- Legal guardianship papers

You may:

- Participate fully in all school activities and programs for which you are eligible.
- Continue to attend the school in which you were last enrolled even if you have moved away from that school's attendance zone or district.
- Receive transportation from your current residence back to your school of origin.
- Qualify automatically for child nutrition programs (free and reduced-price lunches and other district food programs).
- Contact the district liaison to resolve any disputes that arise during the enrollment process.

Parents' responsibilities are to:

- Make sure your child attends school regularly and completes homework and projects on time.
- Attend parent/teacher conferences, Back-to-School Nights, and other school-related activities.
- Stay informed of school rules, regulations, and activities.
- Participate in school advisory/decision-making activities.

For questions about enrolling in school or for assistance with school enrollment, contact:

Your local school district liaison:

Nancy Gutierrez
Pupil Service and Attendance Coordinator
LAUSD Homeless Education Program,
Roybal Annex
121 N. Beaudry Ave.
Los Angeles, CA 90012
Phone: 1-213-202-7581

Your county liaison for the homeless:

Melissa Schoonmaker
Homeless Education Program Manager
School Attendance Review Board /
McKinney-Vento
12830 Columbia Way, ECW-3236
Downey, CA 90242
Phone: 1-562-922-6233

Your state coordinator for the homeless:

Leanne Wheeler
State Coordinator
California Department of Education
1430 N Street, Suite 6208
Sacramento, California 95814
Phone: 1-866-856-8214

California Department of Education

CES REFERRAL FORM

This referral MUST be completed by your SPA's Coordinated Entry System (CES) Community Coordinator or Community Matcher.

CLIENT NAME: _____

CES/HMIS ID: _____ DOB: _____ SPA: _____

REFERRING AGENCY NAME: _____

AGENCY CONTACT: _____

AGENCY ADDRESS: _____

City / State / Zip: _____

AGENCY PHONE: _____

_____

AGENCY CONTACT SIGNATURE

_____

DATE

Please attach agency stamp or business card of Agency Contact completing this form in the box below:

Attach agency stamp or business card:

CES Community Coordinator and Matcher

SPA	Organization	Community Coordinator	Contact Info	Community Matcher	Contact Info
1	Valley Oasis	Diane Grooms	dvgrooms@avdvc.org	Andrea Stocker	astocker@avdvc.org
2	LA Family Housing	Christina Miller	cmiller@lafh.org	Nathaniel Vergrow	nvergow@lafh.org
3	Union Station Homeless Services	Sieglinde Von	svondeffner@unionstationhs.	Sieglinde Von Deffner	svondeffner@unionstationhs.org
4	LAMP, Inc.	Hazel Lopez	hazell@lampcommunity.org	Liz Sanford	matcher@thecenterinhollywood
5	St. Joseph Center	Lindsay Saunders	lsaunders@stjosephctr.org	Kela Caldwell	kcaldwell@stjosephctr.org
6	Special Services for Groups	Takita Salisberry	tsalisberry@hopics.org	Nicole Bay	nbay@hopics.org
7	PATH (People Assisting The Homeless)	Meredith Berkson	meredithb@ePath.org	Jonathan Sanabria	jonathans@ePath.org
8	Harbor Interfaith Services, Inc.	Shari Weaver	sweaver@harborinterfaith.or	Alex Devin	adevin@harborinterfaith.org

Updated 12/06/16

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
FEDERAL HOUSING SUBSIDIES UNIT
HACoLA SHELTER PLUS CARE PROGRAM

Sample Format for Case Manager / Housing Liaison Referral Letter

Must be on Agency letterhead.

First Paragraph

- Just one or two sentences describing your agency's program(s) (Attaching an agency brochure helps.)
- Applicant's entry date into your agency's program
- Applicant's exit date from your agency's program. (If applicable, explain why the Applicant is leaving your agency's program, and identify the linkage schedule and the next provider to whom Applicant will be linked--agency name, case manager name and phone number.)
- Say where the applicant is living at the present time.
    - If he or she is in a shelter or transitional living program, ask the shelter to write a letter on their letterhead (and add their pamphlet, if available).
    - If the applicant is living on the "streets," include information specifying where he or she can be found (e.g., "Ms. Jones resides in the alley directly behind the Baja Fresh Restaurant located at 6043 Hollywood Boulevard, Hollywood, CA 90028. I have met with her for case management at this location on the following dates: 01/23/04, 02/06/04, 03/10/04, and 04/13/04. She was noted by police citation for sleeping in this alley on the flowing dates: 05/23/04, and 05/30/04."

Troubleshooting

- If exit date at shelter or transitional living program has passed, then explain why the Applicant is still in the program.
- *Example*: "Even though Mr. Smith's residential time at Hugh Heffner's Transitional Living Center has expired, we received permission to allow him to stay here until he is approved for a HACoLA Shelter Plus Care Certificate. "
- Be mindful if you allow an Applicant to stay at your facility past their expiration date (i.e., identify why and for how long).

Second Paragraph

- Narrative outline of the Applicant's homeless history, with **NO** time gaps.
- Identify time periods Applicant can't recall, if any.
- This detailed history should begin from when Applicant began seeing the case manager. If that time is less than two years, then the case manager should include the Applicant's recollection of their homelessness prior to engagement.
- Include (1) the specific date Applicant first became homeless and (2) the event that caused Applicant's to become homeless. If the event is documented (e.g.,

eviction papers, motel receipts, etc.) reference them here and include them in the application.
- Identify and explain **all** Applicant telephone numbers and addresses disclosed **anywhere** in the application package, including the address on the Applicant's CDL or other photo ID.
- Explain why Applicant cannot live at / return to these addresses

Third Paragraph
- Explain why you think this Applicant meets target population for Shelter Plus Care (Remember: the Applicant has to be sick enough to meet the service match).
- Mental illness should only be mentioned (e.g., "Mr. Burnett has a mental illness, attends all appointments regularly at the clinic, and is medication compliant.")
- Explain your Applicant's experience with your program
- Always include strengths and positive points concerning the applicant
- Mention Independent Living Skills, especially money management. (Place the person you have chosen for a Shelter Plus Care Certificate into a Community Living Program or Independent Living Skills class.)

Fourth Paragraph
- If children are involved, please state: (1) where they are, (2) who is supporting them, and (3) if the child is in placement, attach court paperwork indicating who has custody and a letter from the Children's Social Worker indicating that the child will be allowed to reside with the applicant in the apartment.
- Criminal Background Checks: Criminal background checks are required for all adult family members (18 years and over) that will be residing with the applicant. Provide information concerning the following:
    - If the adult family member has been convicted of any drug or alcohol related offense, explain and document what treatment (including residential and out patient substance abuse treatment, 12-step meetings, etc.) he or she has been involved in and completed.
    - If the adult family member has been convicted of a violent offence, explain and document what treatment (including anger management classes, and individual therapy, etc.) he or she has been involved in and completed.
- NO CRIMINAL BACK GROUND CHECK HAS BEEN ASKED FOR THE APPLICANT FROM HACoLA (Housing Authority of the County of Los Angeles). This information is collected elsewhere in the application and does not need to be mentioned in the referral letter.

Fifth Paragraph
- Closing remarks and contact information for referring clinician or case manager.

Salutation,

Signature
Title

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

JONATHAN E. SHERIN, M.D., Ph.D., Director
ROBIN KAY, Ph.D., Chief Deputy Director
RODERICK SHANER, M.D., Medical Director

SAMPLE REFERRAL LETTER

November 1, 2016

Eligibility Interviewer
Housing Authority of the County of Los Angeles
Special Programs Operation
700 W. Main Street
Alhambra, CA 91801

RE: Jane Doe, SS# 123-45-6789

Housing Authority of the County of Los Angeles:

I am writing this letter in support of Jane Doe's Shelter Plus Care application. Jane has been a client of the ACTION program since October 18, 2012. ACTION is an assertive community treatment program that assists dually diagnosed consumers with psychotherapy, case management, and psychiatry. Jane has a mental illness and has maintained all scheduled appointments with me for counseling and sees her psychiatrist regularly despite her lack of a fixed nightly residence.

Jane became homeless on January 8, 2013 after fleeing from a domestic violence situation. For the past four years, Jane has lived in inpatient psychiatric hospitals, on the street, crisis residential facilities, LAHSA cold/wet weather shelters, and a garage. We recently met and reviewed her psychiatric treatment history and compiled the following list of dates and locations of Jane's living arrangements. Because of the client's cognitive deficits and memory loss, the following represents the best history this client can recollect:

01/08/2013 to 02/07/2013: 1736 Crisis House, Torrance, CA 90000
02/08/2013 to 03/15/2013: New Image Emergency Shelter, Los Angeles, CA 90000
03/16/2013 to 06/31/2013: Shady Lady Motel, 3434 Sunset Blvd., Hollywood, CA 90000
07/01/2013 to 08/31/2013: Client does not remember where she resided
09/01/2013 to 10/25/2013: Twin Towers Correctional Facility
10/26/2013 to 12/15/2013 "Streets" – Sidewalk at 4th and Main, Los Angeles, CA 90000
12/16/2013 to 12/19/2013: BHC Hospital, Psychiatric Unit, Rosemead, CA 90000
12/20/2013 to 01/19/2014: Excelsior House Crisis Residential Treatment, LA, CA 90000
01/20/2014 to 04/01/2014: "Streets" – Car parked at 1720 E 120th St., Los Angeles, CA 90000 (Car was towed)
04/02/2014 to 04/15/2014: "Streets" – Alley between Augustus Hawkins MHC and King Drew Medical Center, Los Angeles, CA 90000

04/16/2014 to 06/20/2014: Help is on the Way Shelter, Los Angeles, CA 90000
06/21/2014 to 07/26/2014: Client does not remember where she resided
07/27/2014 to 08/05/2014: Brotman Medical Center, Psychiatric Unit, LA, CA 90000
08/06/2014 to 12/15/2014: "Streets" – 2nd and Broadway, Santa Monica, CA 90000
12/16/2014 to 03/15/2015: New Directions Emergency Shelter, West LA, CA 90000
03/16/2015 to 04/10/2015: Weingart Center Shelter, Los Angeles, CA 90000
04/11/2015 to 08/04/2015: "Streets" – Sidewalk at 4th and Main, Los Angeles, CA 90000
08/05/2015 to 08/08/2015: Robert F. Kennedy, Psychiatric Unit, Los Angeles, CA 90000
08/09/2015 to 02/09/2016: Daybreak Transitional Living Program, SM, CA 90000
02/10/2016 to 05/06/2016: Garage/Abandoned Home -- 1796 Raymond St., Los Angeles, CA 90000. The garage lacked cooking facilities, a restroom or shower, running water, electricity, and insulation to keep warm. The roof often leaked when it rains.
05/07/2016 to 05/22/2016: Twin Towers Correctional Facility – Arrested for trespassing
05/23/2016 to 06/15/2016: "Streets" – near Cherokee and Hollywood Blvd., Hollywood, CA 90000
06/15/2016 to 09/15/2016: Jan Clayton Center Residential Substance Abuse Treatment, Hollywood, CA 90000
09/16/2016 to present: PATH Specialized Shelter Bed Program, LA, CA 90000

Jane is an appropriate candidate for the Shelter Plus Care program because she is now medication compliant, has completed courses in parenting, independent living skills, and money management. In the past, Jane successfully maintained a residence and has good independent living skills. Jane is a part of the Money Management Program at Hollywood Mental Health Center, which will also continue to provide the intensive case management that will allow her to maintain independence in the community. In addition, Jane has completed a 90-day residential substance abuse treatment program and continues to maintain a relationship to her facility by attending outpatient groups. Jane also attends 12 Step groups for support and fellowship in recovery.

Jane has an 8-year-old daughter (Sheila Doe) who will live with her mother once she is in a stable living situation. Presently, Sheila resides with client's mother (Marie Doe) at 6703 67th Street, Los Angeles. A letter from client's DCFS social worker indicating the child's current location and the social worker's intent to place the child with client at her new residence is attached.

I appreciate your time in reviewing this case. A Shelter Plus Care certificate would provide an avenue of stability for Jane. If you have any questions or concerns, please feel free to call me at 213-637-5555.

Sincerely,

Daisy Obetsanov, MSW
Psychiatric Social Worker

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES

PROGRAM TRANSMITTAL/REFERRAL FORM

CONTINUUM OF CARE

TO: _____

_____

_____

_____

FROM: _____

This referral <u>MUST</u> be completed by the public agency or by the social service agency contracted with the Housing Authority of the County of Los Angeles (HACoLA).

CLIENT NAME: _____

SSN: _____ DOB: _____

AGENCY ADDRESS: _____

City / State / Zip: _____

AGENCY PHONE: _____

DATE REFFERAL SUBMITTED FOR APPROVAL TO HOUSING AUTHORITY: _____

_____ _____

AGENCY CONTACT SIGNATURE | CLIENT SIGNATURE

_____ _____

DATE | DATE

Please affix agency stamp or business card of Agency Contact completing this form in the box below:

Affix agency stamp or business card:

CONTINUUM OF CARE Program Application Checklist

Applicant Name_____ Social Security #_____

CASE MANAGEMENT FORMS

- ☐ Case Management Agreement (PROVIDED BY CBO: Shelter Plus Care/Continuum of Care only)
- ☐ Out of Service Agreement (Homeless/HOPWA/Shelter Plus Care/Continuum of Care only)
- ☐ Coordinated Entry System/Homeless Family Solutions System Form (Shelter Plus Care/ Continuum of Care only)
- ☐ Homeless Condition Certification (Homeless/HOPWA/Shelter Plus Care/Continuum of Care only)
- ☐ Verification of Disability (if applicable)
- ☐ Statement of Veteran & Family Responsibility (VASH only)
- ☐ Authorization to Release Information
- ☐ Certification of No Conflict of Interest (Shelter Plus Care/Continuum of Care only)
- ☐ Housing Intake Assessment (Shelter Plus Care/Continuum of Care only)

HA Office Use Only
Missing Item(s):
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VERIFICATION OF INCOME (as applicable to household)

- ☐ Application
- ☐ Current Lease Agreement **or** Utility Bills **or** School Records **or** Rent Receipts
- ☐ Employment Letter (original) **or** 2 current consecutive pay stubs **or** payroll history
- ☐ IRS Form 1040/1040A (self-employment) **or** Notarized Statement
- ☐ Social Security/SSI Award Letter
- ☐ Cal-Works/Food Stamps/General Relief/CAPI Notice of Action (current)
- ☐ Foster Care/Adoption Assistance/KinGAP Award Letter **or** 2 current consecutive pay stubs
- ☐ Unemployment/State Disability Award Letter **or** 2 current consecutive pay stubs
- ☐ Workers Compensation Statement **or** 2 current consecutive pay stubs
- ☐ Pension Statement (Retirement/Veterans) **or** last 2 pay stubs
- ☐ Railroad Retirement Award Letter **or** 2 current consecutive pay stubs
- ☐ Alimony Decree/Separation Agreement **or** 2 current consecutive pay stubs
- ☐ Student Registration Notice, Fee Statements **and** Financial Aid or Scholarship Letters
- ☐ Child Support (Payment Warrant History **or** Settlement Agreement)
- ☐ Financial Account Statements (all pages of current statement for each account)
- ☐ Real Estate Assets/Records of Ownership (must include date of disposal)
- ☐ Life insurance Policy Statement (current)
- ☐ Medicare Prescription Drug (Part D) Plan Explanation of Benefits **or** 2 payment coupons
- ☐ Medical Insurance Bill Statement (current)
- ☐ Out-of-Pocket Medical Expenses (Pharmacy Drug History/Receipts/IRS Form)
- ☐ School Verification (for adults over 18 years of age)
- ☐ Other_____

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SUPPLEMENTAL FORMS

- ☐ California Identification/Driver's License (all members)
- ☐ DD-214
- ☐ Social Security (all members)
- ☐ Birth Certificate/Alternative Verification (mandatory for all minors)
- ☐ Doctor's Statement/Hospital Record
- ☐ Criminal Background Consent (except VASH)
- ☐ Authorization for Housing Authority to Obtain Sex Offender Registration Information (VASH only)
- ☐ Parent/Guardian Authorization for Housing Authority to Obtain Sex Offender Registration Information of a Minor
- ☐ DPSS Verification (if applicable)
- ☐ HUD Form 92006 – Supplement to Application for Federally Assisted Housing
- ☐ HUD Form 52675 – Debts Owed to Public Housing Agencies and Terminations (Homeless/Project-Based Voucher/VASH only)

HA Office Use Only
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PLACE HERE

To get a copy of the **HOUSING AUTHORITY SPECIAL PROGRAMS APPLICATION FOR RENTAL ASSISTANCE (12pgs)**, please contact Federal Housing Subsidies Unit (FHSU) to arrange pick up.

Please contact:

Martha Ortiz at
mortiz@dmh.lacounty.gov

or

Jessica Jones-Montgomery at
jjonesmontgomery@dmh.lacounty.gov

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES
ASSISTED HOUSING DIVISION
P.O. Box 1510 • Alhambra • California 91802
Tel: 626.262.4510 • TDD: 855.892.6095 • www.hacola.org

Non-Discrimination Policy

It is the policy of HACoLA to comply with the Fair Housing Act, Title VIII of the Civil Rights Act of 1968, as amended by the Fair Housing Amendments Act of 1988, 42 U.S.C. §§ 3601 *et seq*., by ensuring that housing is available to all persons without regard to race, color, religion, national origin, disability, familial status (having children under age 18), or sex. This policy means that, among other things, HACoLA and its agents or employees must not discriminate in any aspect of housing, including but not limited to denying persons access to housing, because of race, color, religion, national origin, disability, familial status, or sex. Such agents and employees may not:

a. Make unavailable or deny a dwelling to any person because of race, color, religion, national origin, disability, familial status, or sex;

b. Discriminate against any person in the terms, conditions, or privileges of a dwelling, or in the provision of services or facilities in connection therewith, because of race, color, religion, national origin, disability, familial status, or sex;

c. Make, print, or publish, or cause to be made, printed, or published any notice, statement, or advertisement, with respect to a dwelling that indicates any preference, limitation, or discrimination based on race, color, religion, national origin, disability, familial status, or sex, or an intention to make any such preference, limitation, or discrimination, or

d. Coerce, intimidate, threaten, or interfere with any person in the exercise or enjoyment of, or on account of his or her having exercised or enjoyed, or on account of his or her having aided or encouraged any other person in the exercise or enjoyment of, any right granted or protected by the Fair Housing Act.

Any agent or employee who fails to comply with this non-discrimination policy will be subject to appropriate disciplinary action. Any action taken by an agent or employee that results in the unequal treatment of citizens on the basis of race, color, religion, national origin, disability, familial status, or sex, may constitute a violation of state and federal fair housing laws. An individual who believes that he or she is the victim of discrimination may contact the U.S. Department of Housing and Urban Development at 1-207-945-0467, or the U.S. Department of Justice at 1-800-896-7743.

OMB Control # 2502-0581
Exp. (11/30/2015)

Optional and Supplemental Contact Information for HUD-Assisted Housing Applicants

SUPPLEMENT TO APPLICATION FOR FEDERALLY ASSISTED HOUSING

This form is to be provided to each applicant for federally assisted housing

Instructions: Optional Contact Person or Organization: You have the right by law to include as part of your application for housing, the name, address, telephone number, and other relevant information of a family member, friend, or social, health, advocacy, or other organization. This contact information is for the purpose of identifying a person or organization that may be able to help in resolving any issues that may arise during your tenancy or to assist in providing any special care or services you may require. **You may update, remove, or change the information you provide on this form at any time.** You are not required to provide this contact information, but if you choose to do so, please include the relevant information on this form.

☐ Check this box if you choose not to provide the contact information.

Applicant Name:	
Mailing Address:	
Telephone No:	**Cell Phone No:**
Name of Additional Contact Person or Organization:	
Address:	
Telephone No:	**Cell Phone No:**
E-Mail Address (if applicable):	
Relationship to Applicant:	

Reason for Contact: (Check all that apply)

- ☐ Emergency
- ☐ Unable to contact you
- ☐ Termination of rental assistance
- ☐ Eviction from unit
- ☐ Late payment of rent
- ☐ Assist with Recertification Process
- ☐ Change in lease terms
- ☐ Change in house rules
- ☐ Other: _____

Commitment of Housing Authority or Owner: If you are approved for housing, this information will be kept as part of your tenant file. If issues arise during your tenancy or if you require any services or special care, we may contact the person or organization you listed to assist in resolving the issues or in providing any services or special care to you.

Confidentiality Statement: The information provided on this form is confidential and will not be disclosed to anyone except as permitted by the applicant or applicable law.

Legal Notification: Section 644 of the Housing and Community Development Act of 1992 (Public Law 102-550, approved October 28, 1992) requires each applicant for federally assisted housing to be offered the option of providing information regarding an additional contact person or organization. By accepting the applicant's application, the housing provider agrees to comply with the non-discrimination and equal opportunity requirements of 24 CFR section 5.105, including the prohibitions on discrimination in admission to or participation in federally assisted housing programs on the basis of race, color, religion, national origin, sex, disability, and familial status under the Fair Housing Act, and the prohibition on age discrimination under the Age Discrimination Act of 1975.

Signature of Applicant **Date**

Authorization for the Release of Information/ Privacy Act Notice

to the U.S. Department of Housing and Urban Development (HUD) and the Housing Agency/Authority (HA)

U.S. Department of Housing and Urban Development
Office of Public and Indian Housing

PHA requesting release of information; **(Cross out space if none)** (Full address, name of contact person, and date)	IHA requesting release of information: **(Cross out space if none)** (Full address, name of contact person, and date)

Authority: Section 904 of the Stewart B. McKinney Homeless Assistance Amendments Act of 1988, as amended by Section 903 of the Housing and Community Development Act of 1992 and Section 3003 of the Omnibus Budget Reconciliation Act of 1993. This law is found at 42 U.S.C. 3544.

This law requires that you sign a consent form authorizing: (1) HUD and the Housing Agency/Authority (HA) to request verification of salary and wages from current or previous employers; (2) HUD and the HA to request wage and unemployment compensation claim information from the state agency responsible for keeping that information; (3) HUD to request certain tax return information from the U.S. Social Security Administration and the U.S. Internal Revenue Service. The law also requires independent verification of income information. Therefore, HUD or the HA may request information from financial institutions to verify your eligibility and level of benefits.

Purpose: In signing this consent form, you are authorizing HUD and the above-named HA to request income information from the sources listed on the form. HUD and the HA need this information to verify your household's income, in order to ensure that you are eligible for assisted housing benefits and that these benefits are set at the correct level. HUD and the HA may participate in computer matching programs with these sources in order to verify your eligibility and level of benefits.

Uses of Information to be Obtained: HUD is required to protect the income information it obtains in accordance with the Privacy Act of 1974, 5 U.S.C. 552a. HUD may disclose information (other than tax return information) for certain routine uses, such as to other government agencies for law enforcement purposes, to Federal agencies for employment suitability purposes and to HAs for the purpose of determining housing assistance. The HA is also required to protect the income information it obtains in accordance with any applicable State privacy law. HUD and HA employees may be subject to penalties for unauthorized disclosures or improper uses of the income information that is obtained based on the consent form. **Private owners may not request or receive information authorized by this form.**

Who Must Sign the Consent Form: Each member of your household who is 18 years of age or older must sign the consent form. Additional signatures must be obtained from new adult members joining the household or whenever members of the household become 18 years of age.

Persons who apply for or receive assistance under the following programs are required to sign this consent form:

- PHA-owned rental public housing
- Turnkey III Homeownership Opportunities
- Mutual Help Homeownership Opportunity
- Section 23 and 19(c) leased housing
- Section 23 Housing Assistance Payments
- HA-owned rental Indian housing
- Section 8 Rental Certificate
- Section 8 Rental Voucher
- Section 8 Moderate Rehabilitation

Failure to Sign Consent Form: Your failure to sign the consent form may result in the denial of eligibility or termination of assisted housing benefits, or both. Denial of eligibility or termination of benefits is subject to the HA's grievance procedures and Section 8 informal hearing procedures.

Sources of Information To Be Obtained

State Wage Information Collection Agencies. (This consent is limited to wages and unemployment compensation I have received during period(s) within the last 5 years when I have received assisted housing benefits.)

U.S. Social Security Administration (HUD only) (This consent is limited to the wage and self employment information and payments of retirement income as referenced at Section 6103(l)(7)(A) of the Internal Revenue Code.)

U.S. Internal Revenue Service (HUD only) (This consent is limited to unearned income [i.e., interest and dividends].)

Information may also be obtained directly from: (a) current and former employers concerning salary and wages and (b) financial institutions concerning unearned income (i.e., interest and dividends). I understand that income information obtained from these sources will be used to verify information that I provide in determining eligibility for assisted housing programs and the level of benefits. Therefore, this consent form only authorizes release directly from employers and financial institutions of information regarding any period(s) within the last 5 years when I have received assisted housing benefits.

Consent: I consent to allow HUD or the HA to request and obtain income information from the sources listed on this form for the purpose of verifying my eligibility and level of benefits under HUD's assisted housing programs. I understand that HAs that receive income information under this consent form cannot use it to deny, reduce or terminate assistance without first independently verifying what the amount was, whether I actually had access to the funds and when the funds were received. In addition, I must be given an opportunity to contest those determinations.

This consent form expires 15 months after signed.

Signatures:

Head of Household	Date		
Social Security Number (if any) of Head of Household		Other Family Member over age 18	Date
Spouse	Date	Other Family Member over age 18	Date
Other Family Member over age 18	Date	Other Family Member over age 18	Date
Other Family Member over age 18	Date	Other Family Member over age 18	Date

Privacy Act Notice. Authority: The Department of Housing and Urban Development (HUD) is authorized to collect this information by the U.S. Housing Act of 1937 (42 U.S.C. 1437 et. seq.), Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and by the Fair Housing Act (42 U.S.C. 3601-19). The Housing and Community Development Act of 1987 (42 U.S.C. 3543) requires applicants and participants to submit the Social Security Number of each household member who is six years old or older. Purpose: Your income and other information are being collected by HUD to determine your eligibility, the appropriate bedroom size, and the amount your family will pay toward rent and utilities. Other Uses: HUD uses your family income and other information to assist in managing and monitoring HUD-assisted housing programs, to protect the Government's financial interest, and to verify the accuracy of the information you provide. This information may be released to appropriate Federal, State, and local agencies, when relevant, and to civil, criminal, or regulatory investigators and prosecutors. However, the information will not be otherwise disclosed or released outside of HUD, except as permitted or required by law. Penalty: You must provide all of the information requested by the HA, including all Social Security Numbers you, and all other household members age six years and older, have and use. Giving the Social Security Numbers of all household members six years of age and older is mandatory, and not providing the Social Security Numbers will affect your eligibility. Failure to provide any of the requested information may result in a delay or rejection of your eligibility approval.

Penalties for Misusing this Consent:

HUD, the HA and any owner (or any employee of HUD, the HA or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form.

Use of the information collected based on the form HUD 9886 is restricted to the purposes cited on the form HUD 9886. Any person who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000.

Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD, the HA or the owner responsible for the unauthorized disclosure or improper use.

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES
ASSISTED HOUSING DIVISION
700 W. Main Street. Alhambra, CA 91801

AUTHORIZATION FOR RELEASE OF INFORMATION

The undersign(s) do hereby authorize any agency, office, group, organization, business firm, financial institution, public or private school, or governmental entity, to release to the Community Development Commission / Housing Authority of the County of Los Angeles (HACoLA), any information or materials which HACoLA deems necessary to complete and verify my application for participation and/or to maintain my continued assistance under the Section 8 Certificate Program, Housing Voucher Program, Low Income Housing Programs, or any other program that HACoLA may administer.

The information needed may include, but is not limited to: verification or inquiries regarding my identity, household members (including minors in my household), employment, income, financial accounts, assets, school records, allowances or preferences I have claimed, and residency.

The entities which HACoLA may request release of information shall include, but are not limited to: financial institutions (42 U.S.C. Sec 3544); social service agencies; educational institutions; welfare agencies; Veteran's Administration; court clerks; utility companies; workmen's compensation payers; public and private retirement systems; law enforcement agencies; credit providers; postal service; and unemployment insurance agencies.

Records from financial institutions shall include all credit card account statements, loan account statements, mortgage account statements, loan applications, credit applications and any and all other account statements.

It is understood and agreed that this authorization or the information obtained with its use may be given to and used by HACoLA in the administration and enforcement of program rules and regulations and that HACoLA may in the course of its duties obtain such information from other Federal, State, or local agencies including State Employment Security Agencies; Department of Defense; Office of Personnel Management; the Social Security Administration; and welfare and food stamp agencies.

It is with my understanding and consent that a photocopy of this authorization may be used for the purposes stated above. This authorization for release of information expires fifteen months after the date signed.

AUTHORIZATION FOR RELEASE OF INFORMATION (Page 2 of 2)

(This consent form expires 15 months after signed.)

Instructions: Provide head of household's name, social security number, address, phone number and birth date, and name, birth date and social security number (or school attending for minors) of all household members.

Printed Name (Head of Household) Social Security Number

Address City State Zip

Telephone Number Date of Birth

Other Adult in Household	Date of Birth	Social Security Number
Other Adult in Household	Date of Birth	Social Security Number
Other Adult in Household	Date of Birth	Social Security Number
Minor in Household	Date of Birth	School Attending
Minor in Household	Date of Birth	School Attending
Minor in Household	Date of Birth	School Attending
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Minor in Household	Date of Birth	School Attending
Minor in Household	Date of Birth	School Attending

INSTRUCTIONS: All members of the household, 18 years of age and older must sign below.

Signature – Head of Household	**Date**
Signature – Other Adult	**Date**
Signature – Other Adult	**Date**
Signature – Other Adult	**Date**

U.S. Department of Housing and Urban Development

Office of Public and Indian Housing

DEBTS OWED TO PUBLIC HOUSING AGENCIES AND TERMINATIONS

Paperwork Reduction Notice: Public reporting burden for this collection of information is estimated to average 7 minutes per response. This includes the time for respondents to read the document and certify, and any recordkeeping burden. This information will be used in the processing of a tenancy. Response to this request for information is required to receive benefits. The agency may not collect this information, and you are not required to complete this form, unless it displays a currently valid OMB control number. The OMB Number is 2577-0266, and expires 08/31/2016.

NOTICE TO APPLICANTS AND PARTICIPANTS OF THE FOLLOWING HUD RENTAL ASSISTANCE PROGRAMS:

- Public Housing (24 CFR 960)
- Section 8 Housing Choice Voucher, including the Disaster Housing Assistance Program (24 CFR 982)
- Section 8 Moderate Rehabilitation (24 CFR 882)
- Project-Based Voucher (24 CFR 983)

The U.S. Department of Housing and Urban Development maintains a national repository of debts owed to Public Housing Agencies (PHAs) or Section 8 landlords and adverse information of former participants who have voluntarily or involuntarily terminated participation in one of the above-listed HUD rental assistance programs. This information is maintained within HUD's Enterprise Income Verification (EIV) system, which is used by Public Housing Agencies (PHAs) and their management agents to verify employment and income information of program participants, as well as, to reduce administrative and rental assistance payment errors. The EIV system is designed to assist PHAs and HUD in ensuring that families are eligible to participate in HUD rental assistance programs and determining the correct amount of rental assistance a family is eligible for. All PHAs are required to use this system in accordance with HUD regulations at 24 CFR 5.233.

HUD requires PHAs, which administers the above-listed rental housing programs, to report certain information at the conclusion of your participation in a HUD rental assistance program. This notice provides you with information on what information the PHA is required to provide HUD, who will have access to this information, how this information is used and your rights. PHAs are required to provide this notice to all applicants and program participants and you are required to acknowledge receipt of this notice by signing page 2. Each adult household member must sign this form.

What information about you and your tenancy does HUD collect from the PHA?

The following information is collected about each member of your household (family composition): full name, date of birth, and Social Security Number.

The following adverse information is collected once your participation in the housing program has ended, whether you voluntarily or involuntarily move out of an assisted unit:

1. Amount of any balance you owe the PHA or Section 8 landlord (up to $500,000) and explanation for balance owed (i.e. unpaid rent, retroactive rent (due to unreported income and/ or change in family composition) or other charges such as damages, utility charges, etc.); and
2. Whether or not you have entered into a repayment agreement for the amount that you owe the PHA; and
3. Whether or not you have defaulted on a repayment agreement; and
4. Whether or not the PHA has obtained a judgment against you; and
5. Whether or not you have filed for bankruptcy; and
6. The negative reason(s) for your end of participation or any negative status (i.e., abandoned unit, fraud, lease violations, criminal activity, etc.) as of the end of participation date.

Who will have access to the information collected?
This information will be available to HUD employees, PHA employees, and contractors of HUD and PHAs.

How will this information be used?
PHAs will have access to this information during the time of application for rental assistance and reexamination of family income and composition for existing participants. PHAs will be able to access this information to determine a family's suitability for initial or continued rental assistance, and avoid providing limited Federal housing assistance to families who have previously been unable to comply with HUD program requirements. If the reported information is accurate, a PHA may terminate your current rental assistance and deny your future request for HUD rental assistance, subject to PHA policy.

How long is the debt owed and termination information maintained in EIV?
Debt owed and termination information will be maintained in EIV for a period of up to ten (10) years from the end of participation date.

What are my rights?
In accordance with the Federal Privacy Act of 1974, as amended (5 USC 552a) and HUD regulations pertaining to its implementation of the Federal Privacy Act of 1974 (24 CFR Part 16), you have the following rights:

1. To have access to your records maintained by HUD, subject to 24 CFR Part 16.
2. To have an administrative review of HUD's initial denial of your request to have access to your records maintained by HUD.
3. To have incorrect information in your record corrected upon written request.
4. To file an appeal request of an initial adverse determination on correction or amendment of record request within 30 calendar days after the issuance of the written denial.
5. To have your record disclosed to a third party upon receipt of your written and signed request.

What do I do if I dispute the debt or termination information reported about me?
If you disagree with the reported information, you should contact in writing the PHA who has reported this information about you. The PHA's name, address, and telephone numbers are listed on the Debts Owed and Termination Report. You have a right to request and obtain a copy of this report from the PHA. Inform the PHA why you dispute the information and provide any documentation that supports your dispute. HUD's record retention policies at 24 CFR Part 908 and 24 CFR Part 982 provide that the PHA may destroy your records three years from the date your participation in the program ends. To ensure the availability of your records, disputes of the original debt or termination information must be made within three years from the end of participation date; otherwise the debt and termination information will be presumed correct. Only the PHA who reported the adverse information about you can delete or correct your record.

Your filing of bankruptcy will not result in the removal of debt owed or termination information from HUD's EIV system. However, if you have included this debt in your bankruptcy filing and/or this debt has been discharged by the bankruptcy court, your record will be updated to include the bankruptcy indicator, when you provide the PHA with documentation of your bankruptcy status.

The PHA will notify you in writing of its action regarding your dispute within 30 days of receiving your written dispute. If the PHA determines that the disputed information is incorrect, the PHA will update or delete the record. If the PHA determines that the disputed information is correct, the PHA will provide an explanation as to why the information is correct.

This Notice was provided by the below-listed PHA:	**I hereby acknowledge that the PHA provided me with the *Debts Owed to PHAs & Termination N*otice:**
	Signature **Date**
	Printed Name

Tenant ID: _____

PART 4 – DEPARTMENT OF PUBLIC SOCIAL SERVICES (DPSS) – PUBLIC ASSISTANCE

PART 4A - THIS SECTION MUST BE COMPLETED FOR ALL HOUSEHOLD MEMBERS THAT RECEIVE PUBLIC ASSISTANCE INCOME ADMINISTERED BY THE DEPARTMENT OF PUBLIC SOCIAL SERVICES (DPSS).

Is any household member receiving assistance or Public Assistance income administered by DPSS?

☐ YES. List each family member and attach a copy of the DPSS Notice of Action dated within 60 days.

☐ NO. Go to Section 5.

	Household Member Name	Income Type and Amount (Select All that Apply)
1		☐ CalWORKs $_____ ☐ Food Stamps $_____ ☐ General Relief/CAPI $_____
2		☐ CalWORKs $_____ ☐ Food Stamps $_____ ☐ General Relief/CAPI $_____
3		☐ CalWORKs $_____ ☐ Food Stamps $_____ ☐ General Relief/CAPI $_____
4		☐ CalWORKs $_____ ☐ Food Stamps $_____ ☐ General Relief/CAPI $_____

PART 4B – THE HOUSING AUTHORITY REQUIRES YOUR SIGNATURE ON THIS FORM TO VERIFY INCOME FROM PROGRAMS ADMINISTERED BY DPSS. DPSS, NOR ANY PROGRAM IT ADMINISTERS, REQUIRES YOUR SIGNATURE ON THIS FORM.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL DPSS INFORMATION

(This consent form expires 15 months from the date it is signed)

I understand that I have a right to the privacy of my personal information. I also understand that provisions of law protect my information and identity as an applicant or recipient of public assistance. I have been told that the Community Development Commission Housing Authority of the County of Los Angeles ("Authority") wants to use my personal information to determine if I am eligible to receive housing services. I understand that if I sign this below, the Los Angeles County Department of Public Social Services ("DPSS") will share the information they have about me, including whether I receive public assistance, the amount of any assistance, and the sanctions/income reduction information as follows: 1) GAIN sanctions; 2) time limits; 3) persons undocumented; 4) child support; 5) CalLearn; 6) school attendance; and 7) immunizations. I understand that by signing this below, I am voluntarily authorizing DPSS, its agents and employees to share the information they have about me. I acknowledge that before signing this Authorization Form, I have carefully read and fully understand its terms. This authorization will expire 15 months from the date of my signing. I understand that my refusal to sign this Authorization Form will not impact the services I currently receive or am eligible to receive through DPSS; however, refusal to sign may lead to termination of my housing assistance provided by the Housing Authority. I understand that I have the right to revoke this authorization at any time by saying so in writing.

Household Member (print name)	Signature	Date
Household Member (print name)	Signature	Date
Household Member (print name)	Signature	Date
Household Member (print name)	Signature	Date

Client No:

HOUSING AUTHORITY

DECLARATION OF CITIZENSHIP/ELIGIBLE IMMIGRATION STATUS

INSTRUCTIONS: In order to be eligible to receive housing assistance, each resident/program applicant must be within the United States lawfully. Please read the certification carefully and return it as directed. Each family member who is age 18 or older must sign a Certification form The responsible adult who will be living in the unit must sign the Certification form for all family members under the age of 18.

I CERTIFY THAT, under the penalty of perjury, to the best of my knowledge, I am lawfully within the United States because (please check the appropriate boxes):

A. ☐ I am a citizen, naturalized citizen, or a national of the United States.
B. ☐ I have eligible immigration status.
Alien Registration No. _____

I CERTIFY THAT:

C. ☐ I do not have eligible immigration status.
D. ☐ I choose not to state my immigrant status.
E. ☐ I am signing the Certification on behalf of minors(s):

Minor's Name	Birth Date	Relationship	Citizenship Status (select the letter that corresponds with the statement above)	Alien Registration
			A B C D	
			A B C D	
			A B C D	
			A B C D	
			A B C D	

F. ☐ I am signing the certification on behalf of adult family member(s) who do not have eligible immigration status or do not choose to state their immigration status *(head of household or spouse must be a citizen or have eligible immigration status to certify under this category):*

Family Member's Name	Birth Date	Relationship	Citizenship Status (select the letter that corresponds with the statement above)
			C D
			C D
			C D

WARNING: TITLE 18, SECTION 1001 OF THE UNITED STATES CODE STATES THAT A PERSON IS GUILTY OF A FELONY FOR KNOWINGLY AND WILLFULLY MAKING FALSE OR FRAUDULENT STATEMENTS OR REPRESENTATIONS TO ANY DEPARTMENT OR AGENCY OF THE UNITED STATES. IN ADDITION, MAKING FALSE STATEMENTS IS A FELONY UNDER CALIFORNIA STATE LAW (PENAL CODE SECTIONS:115, 118, 487 AND 532) AND MAY RESULT IN CRIMINAL CHARGES INCLUDING BUT NOT LIMITED TO: PERJURY, GRAND THEFT, FILING FALSE DOCUMENTS WITH A PUBLIC OFFICE AND OBTAINING MONEY UNDER FALSE PRETENSES.

SECTION 487i OF THE CALIFORNIA PENAL CODE STATES THAT ANY PERSON WHO DEFRAUDS A HOUSING PROGRAM OF A PUBLIC HOUSING AUTHORITY OF MORE THAN FOUR HUNDRED DOLLARS ($400) IS GUILTY OF GRAND THEFT.

_____ _____ _____

Print Name Signature Date

Client No:

AUTORIDAD DE VIVIENDA

DECLARACIÓN DE CIUDADANÍA/ESTADO INMIGRATORIO ELEGIBLE

INSTRUCCIONES: A fin de reunir los requisitos legales para continuar recibiendo asistencia de vivienda, cada residente o participante del programa debe radicar en los Estados Unidos legalmente. Favor de leer la certificación cuidadosamente y devuélvala como se indica. Todo miembro de la familia que sea mayor de 18 años de edad debe firmar un formulario de certificación. El adulto responsable que va a residir en la vivienda debe firmar el formulario de certificación por todos los miembros de la familia que sean menores de 18 años.

CERTIFICO QUE, bajo pena de perjurio y según mi leal saber y entender, radico legalmente en los Estados Unidos porque (favor de marcar las casillas pertinentes):

A. ☐ Soy ciudadano de los Estados Unidos, ciudadano naturalizado o por nacimiento.
B. ☐ Tengo un estado elegible de inmigración.
Número de cédula _____.

CERTIFICO QUE:

C. ☐ No tengo estado elegible de inmigración.
D. ☐ Opto por no declarar mi estado de inmigración.
E. ☐ Firmo la certificación por parte de un menor o menores:

Nombre del menor	Fecha de Nacimiento	Parentesco	Estado de ciudadanía (seleccione la letra que corresponde con la frase anterior)	Número de cédula
			A B C D	
			A B C D	
			A B C D	
			A B C D	
			A B C D	

F. ☐ Firmo la certificación a nombre de miembros adultos de la familia que no tienen estado elegible de inmigración u optan por no declarar su estado de inmigración *(el jefe de familia o cónyuge debe ser ciudadano o tener estado elegible de inmigración para certificar en esta categoría)*:

Nombre del familiar	Fecha de nacimiento	Parentesco	Estado de inmigración (seleccione la letra que corresponde con la frase anterior)
			C D
			C D
			C D

ADVERTENCIA: EL TÍTULO 18, SECCIÓN 1001 DEL CÓDIGO DE LOS ESTADOS UNIDOS ESTABLECE QUE UNA PERSONA ES CULPABLE DE UN DELITO GRAVE SI A SABIENDAS Y POR VOLUNTAD PROPIA HACE DECLARACIONES FALSAS O FRAUDULENTAS A UN DEPARTAMENTO U OFICINA DE LOS ESTADOS UNIDOS. HACER DECLARACIONES FALSAS ES UN DELITO GRAVE BAJO LA LEY DEL ESTADO DE CALIFORNIA (CÓDIGO PENAL SECCIONES: 115, 118, 487 Y 532) Y PUEDE TRAER COMO CONSECUENCIA CARGOS PENALES, INCLUYENDO PERO NO LIMITADO A: PERJURIO, HURTO MAYOR, ENTREGAR DOCUMENTOS FALSOS A UNA OFICINA PÚBLICA Y OBTENER DINERO DE MANERA FRAUDULENTA.
EL ARTÍCULO 487i DEL CÓDIGO PENAL DEL ESTADO DE CALIFORNIA ESTABLECE QUE TODA PERSONA QUE DEFRAUDE A UN PROGRAMA DE UNA AUTORIDAD DE VIVIENDA POR MÁS DE CUATROCIENTOS DÓLARES ($400) ES CULPABLE DE ROBO MAYOR.

_____ _____ _____

Nombre en letra de molde Firma Fecha

HOUSING AUTHORITY

Client No:

CONSENT FORM TO VERIFY IMMIGRATION STATUS WITH THE U.S. CITIZENSHIP AND IMMIGRATION SERVICES (USCIS)

CONSENT: I consent to allow the Housing Authority to request and to obtain information from the U.S. Citizenship and Immigration Services (USCIS) for the purpose of verifying my eligibility and level of benefits under the Housing Authority's assisted housing programs. I understand that the Housing Authority cannot use it to delay, deny, or terminate housing assistance because of the immigration status of a family member, except as provided in the Department of Housing and Urban Development (HUD) regulations. In addition, I understand I must be given an opportunity to contest the determination with the USCIS or the Housing Authority or both.

Signatures:

ADULT(S): AGE 18 OR OVER

Head of Household (Print Name)	Signature	Date of Birth	Alien Registration No.	Date
Spouse (Print Name)	Signature	Date of Birth	Alien Registration No.	Date
Family Member (Print Name)	Signature	Date of Birth	Alien Registration No.	Date
Family Member (Print Name)	Signature	Date of Birth	Alien Registration No.	Date

MINOR(S): UNDER AGE 18

Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date
Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date
Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date
Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date
Minor's Name (Print Name)	Signature of Responsible Adult	Date of Birth	Alien Registration No.	Date

Who Must Sign: In order to be eligible to receive housing assistance, each noncitizen adult or minor applying for, or currently receiving, housing assistance must be lawfully within the U.S. Please read the Verification Consent Form carefully and sign and return as directed. Please feel free to consult with an immigration lawyer or other Immigration expert of your choosing.

Privacy Act Statement: The information on this form is being collected by Housing Authority to determine the applicant's or participant's eligibility for housing assistance. The Housing Authority may release this information, without responsibility for the further use or transmission of the evidence by the entity receiving it to: (1) HUD, as required by HUD; and (2) to the USCIS for purposes of verification of the Immigration status of each individual and not for any other purpose.

Penalties for misusing this Consent: HUD, the Housing Authority and any owner (or any employee of HUD, the Housing Authority or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form.

Use of the information collected on the consent form is restricted to the purposes cited on the form. Any person who knowing or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or resident/program participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or resident/program participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD, the Housing Authority or the owner responsible for the unauthorized disclosure or improper use.

AUTORIDAD DE LA VIVIENDA

Client No:

FORMULARIO DE AUTORIZACIÓN PARA VERIFICAR EL ESTADO DE INMIGRACIÓN CON EL SERVICIO DE CIUDADANÍA E INMIGRACIÓN DE ESTADOS UNIDOS (USCIS, por sus siglas en inglés)

AUTORIZACIÓN: Le concedo permiso a la Autoridad de la Vivienda a que solicite información del Servicio de Ciudadanía e Inmigración de Estados Unidos (USCIS, por sus siglas en inglés) con el fin de verificar mi elegibilidad y nivel de beneficios dentro de los programas de viviendas subsidiadas de la Autoridad de Vivienda. Tengo entendido que la Autoridad de Vivienda no puede usar la información para demorar, negar o anular la asistencia de vivienda debido al estado de inmigración de uno de los miembros de la familia, salvo como está estipulado por los reglamentos del Departamento de Vivienda y Desarrollo Urbano (HUD). Además, tengo entendido que se me debe dar una oportunidad para impugnar la determinación con el USCIS o con la Autoridad de Vivienda, o ambas.

Firmas:

ADULTO(S): MAYORES DE 18 Años

Jefe de familia (letra de molde)	Firma	Fecha de nac.	Número de cédula	Fecha
Cónyuge (letra de molde)	Firma	Fecha de nac.	Número de cédula	Fecha
Miembro de familia (letra de molde)	Firma	Fecha de nac.	Número de cédula	Fecha
Miembro de familia (letra de molde)	Firma	Fecha de nac.	Número de cédula	Fecha

MENORES DE EDAD: MENORES DE 18 Años

Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha
Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha
Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha
Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha
Nombre del menor (letra de molde)	Firma de adulto responsable	Fecha de nac.	Número de cédula	Fecha

Quién debe firmar: Para ser elegible para la asistencia de vivienda, cada adulto o menor que no sea ciudadano y que esté solicitando o actualmente reciba asistencia de vivienda, debe estar legalmente en los Estados Unidos. Por favor lea cuidadosamente el formulario de autorización de verificación, fírmelo y devuélvalo como se indica. Por favor no dude en consultar a un abogado especializado en asuntos de inmigración u otro perito de inmigración de su elección.

Declaración de Ley de Confidencialidad: La información de este formulario la solicita la Autoridad de Vivienda para determinar la elegibilidad del solicitante o participante para la asistencia de vivienda. La Autoridad de Vivienda puede compartir esta información, sin responsabilidad del uso posterior o envío de evidencia por parte de la entidad que la reciba con: (1) HUD, como lo requiere HUD; y (2) el USCIS para fines de verificación del estado de inmigración de cada individuo y no para otros fines.

Penalidades por el uso inadecuado de esta autorización: HUD, la Autoridad de Vivienda y cualquier propietario (o cualquier empleado de HUD, de la Autoridad de Vivienda o del propietario) estará sujeto a penalidades por divulgaciones sin autorización o por usos inadecuados de la información, según el formulario de autorización.

El uso de la información contenida en este formulario de autorización está limitado a los fines estipulados en el mismo. Cualquier persona que a sabiendas y deliberadamente solicite, obtenga o divulgue cualquier dato usando falsos pretextos con respecto a un solicitante o residente/participante de programa, estará sujeto a un delito menor y será multado hasta $5000. Cualquier solicitante o residente/participante de programa que se vea afectado por la divulgación negligente de información, puede presentar una demanda por daños y solicitar otra compensación, según sea apropiado, en contra de HUD, la Autoridad de Vivienda o el propietario responsable por la divulgación sin autorización o el uso inadecuado de la misma.

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES

DEFINITION OF DISABILITY

CONTINUUM OF CARE PROGRAM

To be eligible for assistance with the Continuum of Care Program, the household must include at least one *person with disabilities*, as defined below. Written documentation that a person's disability meets the program definition must come from a professional licensed by the State to diagnose and treat such as disability. This professional must complete a Certificate of Disability in order to verify the applicant's eligibility for the Continuum of Care Program.

DEFINITION OF DISABILITY

Person with disabilities means a household composed of one or more persons at least one of whom who has a disability.

A. A person shall be considered to have a disability if such person has a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder or brain injury, which is expected to be of long-continued and indefinite duration; substantially impedes his or her ability to live independently; and is of such a nature that such ability could be improved by more suitable housing conditions.

B. A person will also be considered to have a disability if he or she has a developmental disability, which is a severe, chronic disability that—

   1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
   2. Is manifested before the person attains age 22;
   3. Is likely to continue indefinitely;
   4. Results in substantial functional limitations in three or more of the following areas of major life activity:
      a. Self-care;
      b. Receptive and expressive language;
      c. Learning;
      d. Mobility;
      e. Self-direction;
      f. Capacity for independent living; and
      g. Economic self-sufficiency; and
   5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

C. A person will also be considered to have a developmental disability if the individual does not meet three or more of the criteria described in paragraphs 1-5 under section (B) above, but is between the age of zero to nine years, inclusive, and has substantial developmental delay or specific congenital or acquired condition and without services and support has a high probability of meeting those criteria later in life.

D. A person diagnosed with Acquired Immunodeficiency Syndrome (AIDS) or any condition arising from the etiological agent for AIDS, including infection with HIV.

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES

CERTIFICATE OF DISABILITY

CONTINUUM OF CARE PROGRAM

I. ELIGIBILITY

To be eligible for assistance with the Continuum of Care Program, the applicant household must include at least one person with disabilities, as defined on page one of this document. Written documentation that a person's disability meets the program definition must come from a professional licensed by the State to diagnose and treat such as disability. This professional must complete a Certificate of Disability in order to verify the applicant's eligibility for the Continuum of Care Program.

II. APPLICANT RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize the release of information concerning my disability to the Housing Authority of the County of Los Angeles to which I am applying for assistance in the Continuum of Care Program. I understand that the information provided on this certification is required to determine my eligibility for the program.

_____	_____	_____
Signature of Applicant	Print Name	Applicant/Tenant ID

III. CERTIFICATION

I certify that _____is eligible for the Continuum of Care Program based on the program definition on page one of this document. This individual is:

( ) Mentally disabled
( ) Developmentally disabled
( ) Physically disabled
( ) Drug Dependent
( ) Alcohol Dependent
( ) HIV/AIDS

If this individual would require any type of accommodation in order to fulfill their obligations under the Continuum of Care Program, please explain:

_____

_____

I hereby certify that the foregoing information is true and correct to the best of my knowledge.

Warning: Any person who signs this statement and who willingly states as true, any matter which (s)he knows to be false, is subject to the penalties prescribed for perjury in Section 118 of the California Penal Code and Section 11054 of the Welfare and Institutions Code.

Printed Name	Title	License Number
Name of Agency or Department	Signature	Date
Address	City, State, Zip	Telephone Number

HOUSING AUTHORITY
COUNTY OF LOS ANGELES
Assisted Housing Division - P.O. Box 1510, Alhambra, CA 91802

DECLARATION FOR _____ Name of Head of Household: _____

Social Security Number:_____

Contract Number:_____

DECLARATION OF ELIGIBILITY FOR ASSISTED HOUSING PROGRAMS

SECTION ONE	**DECLARATION INSTRUCTIONS** 1) If the person named above is a citizen, national or eligible non-citizen, check the box for Declaration A or B as applicable. Only one Declaration box should be checked. 2) Print the name of the person on the blank line in the Declaration statement you choose. Then proceed to complete Section Two. Both Sections One and Two must be completed. **NOTE: Do not complete this declaration for individuals who: 1) are not U.S. citizens or nationals; 2) are not eligible non-citizens or 3) do not wish to disclose their citizenship status.** For these individuals, the head of Household should complete the enclosed "Listing of Non-Contending Family Members" and sign and date it. If the form does not apply for the individual named above, mark this form "does not apply" and return it. **Each member of the family MUST either complete a Declaration or be named on the Listing of Non-Contending Family Members.**

☐ **A. DECLARATION OF U.S. CITIZEN OR U.S. NATIONAL**

I declare that _____ is a U. S. citizen or national.

☐ **B. DECLARATION OF ELIGIBLE NON-CITIZEN STATUS**

I declare that _____ is an eligible non-citizen and can provide documentation to verify one of the non-citizen categories shown below.

IF STATUS "B" IS CHECKED, AN APPOINTMENT WILL BE MADE AT WHICH YOU WILL BE REQUIRED TO SUBMIT AN ORIGINAL IMMIGRATION AND NATURALIZATION SERVICE DOCUMENT VERIFYING ELIGIBLE STATUS.

A lawfully admitted permanent resident, immigrant or special agricultural worker, granted temporary resident status.

A non-citizen who entered the U.S. before 1/1/72, and has lived in the U.S. continuously. I am not ineligible for citizenship, and has been deemed lawfully admitted for permanent residence under section 210 or 21OA of the INA.

A non-citizen with lawful Refugee status, Asylum status, or under conditional entry because of persecution or fear of persecution or because of being uprooted by catastrophic national calamity.

A non-citizen lawfully present in the U.S. under Parole status.

A person lawfully present in the U.S. as a result of the Attorney General's withholding deportation. (Threat to life or freedom)

A non-citizen admitted to the U.S. under Amnesty provisions.

A non-citizen who was 62 years of age or older **and** was receiving federal housing assistance under a covered program on June 19, 1995. (Proof of age and participation on a federal housing program required)

SECTION TWO	**CERTIFICATION AND SIGNATURE** **Persons over eighteen must sign their own declaration below; the adult in the household who is completing a declaration for a child must sign the adult's name below to complete a child's declaration.**

I declare, under penalty of perjury under the laws of the State of California, that the above declaration is true and correct. I understand that false statements or misrepresentation of citizenship status may result in cancellation or termination of assistance.

Executed the _____ day of _____ , 20 _____ at _____ , California.
[Date] [Month] [Year] [City]

APPLICANT/RESIDENT SIGNATURE X_____

Housing Authority of the County of Los Angeles

HOMELESS CONDITION CERTIFICATION

(MUST ONLY BE COMPLETED BY REFERRING AGENCY)

Section I, II & III **MUST** be completed by the referring agency. Both sections **MUST** be completed in order for the application to be considered.

REFERRING AGENCY NAME: _____

APPLICANT NAME: _____

APPLICANT'S CURRENT RESIDENT ADDRESS:

_____

(PO BOX ADDRESS IS NOT ACCEPTABLE)

Section I. CHECK THE APPROPRIATE HOMELESS STATUS AND ATTACH THE REQUIRED HOMELESSNESS VERIFICATION TO THIS WORKSHEET.

Homeless Category	Homeless Status	Type of Verification Required
Category 1: **Literally Homeless**	☐ Persons living on the street.	**Preferred order:** **1.** Third party verification: Written referral by another housing or service provider certifying the applicant's homelessness status (including efforts made to obtain housing); **2.** Intake worker observation: letter from the *referring agency* certifying the outreach or intake worker's first hand knowledge of the applicant/family's homelessness condition (living on the streets) including efforts made to obtain housing. The verification letter must be signed and dated; **-OR-** An HMIS printout documenting receipt of one of the above listed forms of verification; provided that it retains an auditable history of all entries, including the person who entered the data, the date of entry, the change made, **AND** clearly document how the applicant's living condition was verified; or **3.** Self certification: Certification by the individual/head of household stating that (s)he was living on the

		streets. **<u>**For CoC Program Chronically Homeless Applicants:**</u> An individual's self-certification ***must*** be accompanied by the intake worker's documentation of the applicant/family's homelessness condition (living on the streets) including efforts made to obtain evidence in paragraph 1 and 2 listed above.
Category 1: **Literally Homeless**	☐ Persons coming from an emergency shelter, transitional housing**, hotel/motel paid for by charitable organizations, or federal/state/local government programs for low-income individuals. **<u>** CoC Program Applicants: One stay in Transitional Housing may be considered as a single episode of homelessness for eligibility under chronically Homelessness.</u>**	**Preferred order:** **1.** <u>Third party verification:</u> Written referral by another housing or service provider certifying the applicant's homelessness status as that of one who is living in an emergency shelter, transitional housing or hotels/motels paid for by charitable organizations or federal, state or local government programs for low income individuals. The certification must be signed and dated and include information on where the housing was located, which organization provided the funding, and include efforts made to obtain housing; **2.** <u>Intake worker observation:</u> (If certification from the original referring agency cannot be provided), A letter from the *referring* agency certifying the intake worker's firsthand knowledge of the individual/family living in emergency shelter, transitional housing or hotels/motels paid for by charitable organizations or federal, state or local government programs for low income individuals. The certification must be signed and dated, include information on where the housing was located, which organization provided the funding, and include efforts made to obtain housing; **-OR-** <u>An HMIS printout documenting</u>

		receipt of one of the above listed forms of verification. The HMIS printout should reflect the name of the person who entered the data, the date of entry, **and** clearly document how the applicant's living condition was verified; or **3.** Self certification: Certification by the individual/head of household stating that (s)he was living in an emergency shelter, transitional housing or hotels/motels paid for by charitable organizations or federal, state or local government programs for low income individuals. The certification must be signed and dated and include information on where the housing was located, which organization provided the funding, and include efforts made to obtain housing. ****For CoC Program Chronically Homeless Applicants:** An individual's certification ***must*** be accompanied by the intake worker's documentation of the applicant/family's homelessness condition including efforts made to obtain evidence in paragraph 1 and 2 listed above.
Category 1: **Literally Homeless**	☐ Persons coming from an institution where he/she stayed for 90 days or less **and** resided in an emergency shelter or was on the street immediately before entering the institution.	**Preferred order:** **1.** Third party verification: Written referral by another housing or service provider certifying the applicant's homelessness status as that of one who is exiting an institution where living arrangements cannot be provided. The referral must be signed and dated, include the location of the institution, and the efforts made to obtain housing; **2.** Intake worker observation (If certification from the original referring agency cannot be provided): A letter from the intake worker at the *referring* agency certifying his or her firsthand

		knowledge of the individual/family living in an emergency shelter or on the streets before entering the institution. The certification must be signed and dated, include the location of the institution, and the efforts made to obtain housing; **-OR-** An HMIS printout documenting receipt of one of the above listed forms of verification. The HMIS printout should reflect the name of the person who entered the data, the date of entry, **and** clearly document how the applicant's living condition was verified; or **3.** Self certification: Certification by the individual/head of household stating that (s)he was living in an institution. The certification must be signed and dated, include the location of the institution, and include efforts made to obtain housing. **And one of the following:** 1. Discharge paperwork from the institution, **or** a written statement from appropriate official of the institution disclosing the dates of stay **or** an oral statement recorded in writing by the referring agency. The oral statement must be certified by the intake worker from the referring agency. 2. If the intake worker from the referring agency is unable to obtain this documentation from an official at the institution, the referring agency must provide documentation of the intake worker's due diligence in attempting to obtain the information **and** the applicant's self-certification that he or she is exiting or just exited an institution where he

		or she resided for 90 days or less.
Category 4: **Fleeing/ Attempting to Flee Domestic Violence**	☐ Person or family who is fleeing or attempting to flee from domestic violence, dating violence, sexual assault, victims of human or sex trafficking, stalking, or other dangerous or life-threatening conditions related to violence (that has taken place in the person or family's primary nighttime residence or has made them afraid to return to the primary nighttime residence).	A signed and dated self-certification or certification made by the victim service provider's intake worker, attesting that the applicant was fleeing from that situation, that no subsequent residence has been identified, and that applicant lacks the resources and support networks to obtain other permanent housing. If the person or family is not admitted to a domestic violence or shelter receiving services from a victims service provider, a self-certification should be accompanied by a written observation from the intake worker or the referring agency (other social service, law enforcement or legal agency, pastoral counselor or any other organization that the person or family has sought assistance from) attesting that the applicant was fleeing from that situation, that no subsequent residence has been identified, and the applicant lacks the resources and support networks to obtain other permanent housing. *If obtaining third party verification will jeopardize the applicant's safety, self or head of household certification shall be obtained instead.*

Section II. REFERRING AGENCY SUMMARY

How did applicant become homeless? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

The above applicant has been homeless since: _____
(INITIAL DATE OF HOMELESSNESS)

HISTORY: Since the initial date of homelessness, the above applicant's homeless history has been as follows: (include explanations on addresses if different from the shelter address).

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Section III. CHRONIC HOMELESS HISTORY

Is Applicant Chronically Homeless? Yes ☐ No ☐

<u>If applicant is Chronically Homeless</u>, this section MUST be completed. If applicant is chronically homeless and applying for assistance under the Continuum of Care Program, this form MUST be attached to the supplemental questionnaire titled, CoC Program Chronically Homeless Certification. Please include complete addresses of where the applicant has been staying (if on the streets, include city name and street name).

<u>Name of Shelter/address</u>	**<u>Entry Date</u>**	**<u>Exit Date</u>**
1._____		
2._____		
3._____		
4._____		
5._____		

Note: All written verification provided from the emergency shelters, transitional housing and referring agency must be the original document and on the respective agency's letterhead. Letter must include facility address, phone number, and contact person's name.

I certify that all the information provided is true and correct to the best of my knowledge.

_____ _____
Applicant's Signature Date

_____ _____
Referring Case Manager's Signature Date

_____
Referring Agency Address

Affix Office Stamp or Business Card

Continuum of Care Program
Chronic Homeless Definition
Certification

Category	Status	Description	Record Keeping Requirements
Category 1	A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:	(i) Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and	
→	→	(ii) Has been homeless and living as described in paragraph (1)(i) of this definition continuously for at least 12 months or cumulatively on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and at least 3 breaks in homelessness separating the occasions of at least 7 consecutive nights of ***not*** living as described in paragraph (1)(i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place ***not*** meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility. Transitional Housing stays are not considered part of chronic homelessness; therefore, a chronically homeless person who enters transitional housing does not maintain that status for purposes of eligibility for other permanent supportive housing (PSH), ***except*** under the following two conditions: • VA Funded Transitional Housing stays for chronically homeless Veterans – that enter the VA healthcare system and where their eligibility or chronically homeless status is determined at the initial point of intake will be maintained throughout the entire time they're under the VA's care, including the time they spent in programs such as the Grant Per Diem (GPD) Program which makes them	**I. Documenting Continuous Homelessness:** Where 12 months of continuous homelessness evidence (with no breaks) is not already recorded in HMIS, the following may be obtained: • A written record from a homeless service provider (which may include local law enforcement officials or business owners who have eye witnessed the homeless person seeking assistance living on the streets); or • Up to 3 months of homelessness self certified by the individual seeking assistance, stating that he or she resided in a place not meant for human habitation, including attempts to obtain third party evidence. **II. Documenting Cumulative Episodes of Homelessness:** Where 12 months of cumulative evidence (thus four occasions of homelessness over the last three years with 3 breaks) is not already recorded in HMIS, the following may be obtained: • Intake worker observation or third-party documentation from a homeless service provider (as described above) *of a single encounter* within the month is sufficient to consider an individual as homeless and living or residing in a place not meant for human habitation, for the entire calendar month (*e.g.,* an encounter on May 5, 2015, counts for May 1—May 31, 2015), unless there is evidence that there have been at least 7 consecutive nights of ***not*** living or residing in a place not meant for human habitation during that month (*e.g.,* evidence in HMIS of a stay in transitional housing);and • Recorded breaks in homelessness of at least 7 consecutive nights (***not*** living or residing in a place not meant for human habitation) between separate occasions either recorded in HMIS or self-certified (documented entirely based on a self-report by the individual seeking assistance); • Evidence of stays in institutional care facilities fewer than 90 days included in the total of at least 12 months of living or residing in a place not meant for human habitation, must include the evidence in

		eligible for any HUD-VASH or	

Category	Status	Description	Record Keeping Requirements
		CoC permanent supportive housing dedicated to the chronically homeless; provided they were chronically homeless prior to entering the VAs care. The time in GPD however, would not count towards the applicant's total length of time homeless. • Transitional Housing stays used as "Bridge Housing" – for chronically homeless households that have been selected for a permanent supportive housing program (are with voucher in hand) and searching for a unit, would be permitted to temporarily reside in a transitional housing unit while maintaining their eligibility although that time would not be counted as chronically homeless.	paragraphs (A) through (B) of this section and evidence described in paragraphs (A) through (D) of this section that the individual was living or residing in a place ***not*** meant for human habitation immediately prior to entering the institutional care facility; and • For at least 75 percent of the chronically homeless individuals and families assisted by a recipient in a given project during an operating year, no more than 3 months of living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter may be documented via self-certification. • In rare circumstances, up to 25% of households served by a project in any operating year, can document up to the full 12 months of homelessness through a client's own self–certification.
Category 2	→	An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility;	If an individual qualifies as chronically homeless under paragraph (2) of this Chronically homeless definition because he or she has been residing in an institutional care facility for fewer than 90 days and met all of the criteria in paragraph (1) of the definition, before entering that facility, evidence **must** include the following:

			Discharge paperwork or a written or oral referral from a social worker, case manager, or other appropriate official of the institutional care facility stating the beginning and end dates of the time residing in the institutional care facility. All oral statements must be recorded by the intake worker; or Where evidence in paragraph (A) of this section is not obtainable, a written record of the intake worker's due diligence in attempting to obtain the evidence described in paragraph (A) and a certification by the individual seeking assistance that states that he or she is exiting or has just exited an institutional care facility where he or she resided for fewer than 90 days; and (C) Evidence that the individual met the criteria in paragraph (1) of this definition for ''Chronically homeless'', immediately prior to entry into the institutional care facility.
Category 3	⟶	A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.	Evidence that the adult head of household (or if there is no adult in the family, a minor head of household) met all of the criteria for category (1) or (2) of the definition.

I certify that all the information provided is true and correct to the best of my knowledge.

_____ _____

Applicant's Signature Date

_____ _____

Referring Case Manager's Signature Date

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES
700 W. MAIN STREET, ALHAMBRA, CA 91801

CONTINUUM OF CARE PROGRAM
OUT OF SERVICE AREA AGREEMENT

You have been identified as a possible candidate to participate in the Continuum of Care program. However, your current home and/or employment address is outside of the area regularly serviced by the Housing Authority of the County of Los Angeles (HACoLA).

While HACoLA is able to assist families that live or work outside of its regular boundaries, such families must live in HACoLA's jurisdiction for the duration of their housing assistance.

If, given this requirement, you continue to be interested in the Continuum of Care program, please read, sign and date the statement below.

I certify that I have been advised that my current home and/or work address are not within HACoLA's regular service area. I have also been advised that if I am selected for admission into the Continuum of Care program, I will be required to live in HACoLA's jurisdiction (service area), and will not have the right to port out to another jurisdiction, for the duration of my assistance.

Upon receipt of my Continuum of Care certificate, I agree to find a unit within HACoLA's jurisdiction.

_____
Print Name

_____
Participant Signature

_____
Date

Housing Authority of the County of Los Angeles
Assisted Housing Division
P. O. Box 1510, Alhambra, CA 91802

Tenant Name: _____
HOH Social Security #: ___ - ___ - ____

VERIFICATION CONSENT FORM

A Verification Consent Form must be completed by each adult who declares eligible immigration status. Please read the form carefully, then sign and return the form to the Housing Authority within ten (10) days of the date of this form. For each child, this form must be signed by an adult member living in the household.

I understand that the evidence of eligible immigration status submitted to the Housing Authority for the person named below may be released by the Housing Authority to the U.S. Department of Housing and Urban Development (HUD) or to the Immigration and Naturalization Service (INS) for purposes of verification of the immigration status without responsibility for the further use or transmission of the evidence by the entity receiving the information.

I understand that HUD may release evidence of eligible immigration status to the INS for purposes of establishing eligibility for financial assistance and level of benefits under HUD's Conventional Housing Programs and not for any other purpose. HUD is not responsible for the further use or transmission of the evidence or other information by the INS.

_____ - -
Print NAME OF PERSON SS#

_____
Relationship to Head of Household

_____
APPLICANT/RESIDENT SIGNATURE DATE

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES
Assisted Housing Division – P.O. Box 1510 – Alhambra, CA 91802

Name of Head of Household: _____

Social Security Number: _____

Contact Number: _____

LISTING OF NON-CONTENDING FAMILY MEMBERS

When to use this form: If some members of the family decide not to claim that they have eligible immigrant status, but other members of the family establish their citizenship or eligible immigrant status, the family may be considered for assistance. The head of household must provide the names of all family members who do not contend that they have eligible immigrant status and who will not submit either a Declaration or documentation of eligible immigrant status.

Instructions:

1) In the space below, type or legibly print the names of all family members who do not contend that they have eligible immigrant status and who will not submit either a Declaration or documentation of eligible immigrant status.

2) The form must be signed and dated by either a Head of Household or a Co-head/Spouse.

I, _____ , certify under penalty of perjury that the persons listed
(Head of Household/Co-head/Spouse)

below are members of my household who have elected not to contend that he or she has eligible immigration status.

_____
(First Name, Middle Initial(s), Last Name)

_____
(First Name, Middle Initial(s), Last Name)

_____
(First Name, Middle Initial(s), Last Name)

_____
(First Name, Middle Initial(s), Last Name)

_____
(First Name, Middle Initial(s), Last Name)

_____ _____
Signature of Head of Household/Co-head/Spouse Date

*If there are additional names to be listed, please list them on the back of this form.

MOVE IN NOTIFICATION AGREEMENT

To be read and signed by applicant and case manager:

Name of Applicant_____

Name of Clinic/Agency DMH /_____

I certify that I have been advised and understand that if I move into a unit before:

- It passes inspection,
- The Housing Authority – County of Los Angeles (HaCoLa), the owner of the property and I have signed the contract,
- I receive authorization from the Housing Authority to move in.

I may subject myself to the following:

- Being financially responsible for the rent until the unit passes inspection, the contract is signed, and housing authority gives gives authorization to move in,
- ~~Moving out of the unit if it does not pass inspection, or if the contract~~ is not signed,
- Being responsible for any expenses/damages incurred during the time I occupied the unit,
- Being responsible for paying relocation costs,
- Being responsible for locating another unit with the assistance of my case manager if the voucher/certificate has not expired.

I, the case manager, advised_____of the
Applicant
above terms and agreements.

_____ _____
Applicant Signature Date

_____ _____
Case Manager Signature Date

SPE:spb
Revised 3/29/06

ID:

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES
12131 Telegraph Road • PO Box 2129 • Santa Fe Springs, CA 90670

REQUEST FOR REASONABLE ACCOMMODATION

INSTRUCTIONS: The REQUESTOR completes and signs Section I. A qualified professional who has knowledge of the disability completes and signs Section II. The Housing Authority will review your request as soon as we receive this completed form.

SECTION I. REASONABLE ACCOMMODATION REQUEST

Name of Disabled Individual	Address
Last Four Digits of Social Security Number XXX-XX-	Phone number:
Please describe the accommodation you are requesting:	

CERTIFICATION

The person filling out this form is:
- ☐ The individual in need of an accommodation
- ☐ An authorized representative of the Disabled Individual in need of an accommodation

I certify that by signing below, the person in need of the accommodation is a person with disabilities under the following definition:

(1) An individual with a mental or physical impairment that limits one or more major life activities, or
(2) An individual who is regarded as having such an impairment; or
(3) An individual who has a record of such impairment.

Release of Information Authorization (completed by disabled individual or authorized representative)

I hereby authorize the release of information regarding the need for a reasonable accommodation. I understand that the information the Housing Authority obtains will be kept confidential and used solely to determine if an accommodation should be provided.

_____ _____ _____
Print Name Signature Date

SECTION II. STATEMENT OF KNOWLEDGEABLE PROFESSIONAL

The above individual has indicated you are a qualified professional who is knowledgeable about his/her disability. He/she has signed the release above, authorizing you to confirm his/her statement of disability and resulting need for the reasonable accommodation stated above. Please take a moment to complete this portion of the form. You may use the back if necessary. Since you may be called for to confirm the necessity of this request, please keep a record of this form on file. **Once complete, mail back to:**

The Housing Authority of the County of Los Angeles
12131 Telegraph Rd.
Santa Fe Springs, CA 90670

1. Is the accommodation requested necessary for the requestor to enjoy the use of their home or common grounds and/or have meaningful access to housing programs? (Please be specific):

   _____

   _____

2. Without disclosing confidential medical information or diagnoses, please explain the connection between the individual's disability and the requested accommodation:

   _____

   _____

3. Is there an alternative accommodation that would be as effective as the requested accommodation in removing any barriers to the requestor's housing? _____

4. If the disability is temporary in nature, please provide an estimated date you expect the disability to end: _____

I certify that the individual in need of the above stated accommodation is a disabled individual who at minimum meets the definition of disability listed below:

(1) An individual with a mental or physical impairment that limits one or more major life activities, or
(2) An individual who is regarded as having such an impairment; or
(3) An individual who has a record of such impairment.

By signing below, I certify that the foregoing information is true and correct to the best of my knowledge.

Warning: Any person who signs this statement and who willingly states as true, any matter which (s)he knows to be false, is subject to the penalties prescribed for perjury in Section 118 of the California Penal Code and Section 11054 of the Welfare and Institutions Code.

_____ _____ _____
Print Name and Title Signature Date

_____ _____ _____
Street Address City, State and Zip Phone/Contact number

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES
ASSISTED HOUSING DIVISION
700 W. MAIN STREET ● ALHAMBRA ● CA 91801

PARENT/GUARDIAN AUTHORIZATION FOR HOUSING AUTHORITY TO OBTAIN SEX OFFENDER REGISTRATION INFORMATION OF A MINOR

Please complete this form for each household member between the *ages of 13 through 17 years old.*

In accordance with Section 982.553(2)(i) of Title 24 of the Code of Federal Regulations and Section 2.8.2 of the Administrative Plan for the Housing Authority of the County of Los Angeles (HACoLA), HACoLA will deny admission into the Section 8 program to any applicant, including **minors between the ages of 13 to 17 years of age**, who is subject to lifetime registration under a state sex offender registration program. In order to identify any such applicants, HACoLA is authorized to obtain sex offender registration information from the State of California Department of Justice.

By completing this form and signing below, you are authorizing HACoLA to obtain sex offender registration information from the State of California Department of Justice with respect to a member of your household (identified below) between the ***ages of 13 and 17 years of age***. The information obtained by HACoLA is maintained confidentially and will solely be used for the purpose of determining admissions to HACoLA's Section 8 Rental Assistance Program. The information obtained will be destroyed no more than 30 days after a final decision is made, including completion of any administrative reviews and/or legal challenges.

Section I: Parent/Guardian Authorization

Parent/Guardian Name (Print): _____ **SSN:** _____

Parent/Guardian Signature: _____ **Date:** _____

Section II: To be Completed With Minor's Information Only

Last Name: _____ First Name: _____

Middle Name: _____ Social Security #: ___-___-___

Address: _____

CA Driver's License #: _____ CA Identification #: _____

Date of Birth (DOB): ___/___/___ Sex: Female ☐ Male ☐

Has she/he been licensed to drive in another state? ☐ Yes ☐ No

If yes, which state? _____ When? ___/___/___

Has she/he ever been known by another name? ☐ Yes ☐ No

If yes, please list all other names (a.k.a.):

1. _____ 3. _____
2. _____ 4. _____

Is the minor subject to a lifetime registration requirement under a state sex offender registration program?

☐ Yes ☐ No If yes, please explain and provide incident dates: _____

_____

Please Do Not Write Below This Line

Office Use Only

Head of household name:		Head of household SS#:	- -
Program	Unit	Return to (Print HACoLA staff name)	

Applicant Participant	Port-in? Yes No	Initial PHA:		Absorb Bill
Final Disposition:	Suitable Denied			

Reviewed By: **Date**

Housing Authority of the County of Los Angeles
Assisted Housing Division ♦ 700 W. Main St., P.O. Box 1510
Alhambra, CA 91801

Date:

SSN: _____
Family Member: _____

GENERAL AFFIDAVIT

STATE OF CALIFORNIA
COUNTY OF LOS ANGELES

I, _____ residing at _____

_____ certify through my Signature that the statement given below is true and correct to the best of my knowledge and belief:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ANY PERSON WHO SIGNS THIS STATEMENT AND WHO WILLFULLY STATES AS TRUE ANY MATERIAL MATTER WHICH HE/SHE KNOWS TO BE FALSE IS SUBJECT TO THE PENALTIES PRESCRIBED FOR PERJURY IN THE PENAL CODE OF THE STATE OF CALIFORNIA AND/OR THE UNITED STATES CODE.

Applicant/Participant Signature: _____ Date: _____

PLACE HERE

INCOME VERIFICATION including the following:

- Verification of Employment and Earnings (2 months of pay stubs) (if applicable)
- Verification of DPSS Assistance (Notice of Action)
- Verification of Social Security Benefits
- Unemployment / State Disability Insurance Award Letter **or** 2 consecutive check stubs
- Child Support (Payment Warrant History Chart or Settlement Agreement)
- Adoption / Foster Care / Kin-Gap Assistance Payment Letter **or** 2 consecutive check stubs
- Self-Employment – all pages of most recent year Tax Returns, W'2s & 1099s
- Bank Verification of Income and Assets (1 month bank statement) *for* ***every*** *household bank account*
- Verification of Contributions Received
- Pension Statement (Retirement/Veterans) **or** last 2 pay stubs
- Life Insurance Policy Statement (current)

See other examples of Income Verification on
Continuum of Care Program Application Checklist

PLACE HERE

Copy of each household member's California Identification Card (ID) or Driver's License. **If the CA ID/DL expires before the client is housed, the application will be withdrawn;** therefore, if the ID/DL is within 6 months of expiration, ask the client to renew their ID at the DMV. Submit a copy of the DMV application/receipt with the HACoLA application.

-and-

Copy of each household member's **signed** Social Security Card. If it is not signed, the application will be returned to the clinic/agency that submitted it.